

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 3 6 3

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 1. FOR STATE REGISTRAR  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>RUTH Pratt ARMOLD</i>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>11-14-81</i>  |   | 2b. HOUR<br>MIN.<br><i>10 45 AM</i>  |
| 3. SEX<br><i>Female</i>   | 4. RACE<br><i>White</i>                    | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>JAN 19 1902</i>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS HRS. MIN.<br><i>79</i>                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>D.C.</i>  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Anne Arundel</i> MD  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Annapolis</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Anne Arundel General</i>                    |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i>                          | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Home</i>   |
| 13a. STATE<br><i>MD</i>   | 13b. COUNTY<br><i>AA</i>                   | 13c. CITY OR TOWN<br><i>Annapolis</i>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><i>219 Westwood Road</i>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Sidney Pratt</i>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Ella Snyder</i>   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>No</i> |  |
| 16b. SOCIAL SECURITY NO.<br><i>214-38-1005</i>  |  | 17. INFORMANT<br><i>Walter Armold</i>   |   | ADDRESS<br><i>Same as #13</i>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>CHF</i><br><i>4254</i><br>Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Cardiomyopathy</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><i>Urinary Tract Infection</i>  |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)                                |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.         |  |   |   |   |  |
| 22b. SIGNATURE<br><i>Jack R. Lichtenstein</i>   |  |   |   | 22c. DATE SIGNED<br><i>11/14/81</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Jack R. Lichtenstein</i>  |  |   |   | 22e. ADDRESS<br><i>20 Ridgley Ave. Annapolis, Md.</i>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>Nov. 17, 1981</i>   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Hillcrest Cemetery</i>                                 |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Annapolis AA MD</i>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Taylor Funeral Chapel, Annapolis, MD</i>   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 18 1981</i>   |   |  |
|   |  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Frances Jean Nathan</i>  |   |  |

Handwritten text, likely a letter or document, with some legible words such as "D.C.", "USA", "Anne Arnold", and "Hans Arnold". The text is written in cursive and is somewhat faded.

Handwritten text, likely a letter or document, with some legible words such as "D.C.", "USA", "Anne Arnold", and "Hans Arnold". The text is written in cursive and is somewhat faded.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 3 6 4

FOR  
1 - STATE  
REGISTRAR

REG. NO.

EST

|  |  |  |   |   |                                   |  |  |
|--|--|--|---|---|-----------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>SAMUEL AHMUTY, SR.</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 18, 1981</b> |   | 2b. HOUR<br>A M<br><b>11:25 A</b> |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>W</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 5 93</b>  |                                   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YEARS MONTHS DAYS<br><b>87 8 8</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York City</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |   |   |                                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Accountant</b>   |  |  |   |   |                                   |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>AA</b>   |   | 13c. CITY OR TOWN<br><b>Odenton</b>   |                                   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 13e. STREET ADDRESS<br><b>317 Nevada Avenue</b>  |  |  |   |   |                                   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Matthew Ahmuty</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Maria Kohlenberg</b>   |   |   |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-34-8155</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Alice Ahmuty, Same as 13</b>   |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b><br><b>5647</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>CONGESTIVE HEART FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>unknown</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>30 minutes</b> |  |  |   |   |                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)   |  |  |   |   |                                   |  |  |
| 19a. DATE OF OPERATION<br><b>11/13/81</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Megacolon and partial bowel obstruction</b>   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |                                   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.   |  |  |   |   |                                   |  |  |
| 22b. SIGNATURE<br><b>John F. Kressler, M.D.</b>  |  | DEGREE<br><b>M.D.</b>  |   | ATTENDING MEDICAL STAFF<br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>               |                                   | 22c. DATE SIGNED<br><b>11/18/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN F. KRESSLER, M.D.</b>   |  | 22e. ADDRESS<br><b>7445A FURNACE BRANCH ROAD<br/>GLEN BURNIE, MARYLAND 21061</b>   |   |   |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>21 Nov 81</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Epiphany Cemetery</b>  |                                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Odenton AA MD</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>James S. Kirkley, Glen Burnie, MD</b>   |  | ADDRESS  |   | 25a. DATE REC'D BY REGISTRAR<br><b>NOV 20 1981</b>  |                                   | 25b. REGISTRAR'S SIGNATURE<br><b>James S. Kirkley</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>OPAL HARRIS ALLARD   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 6 81 |   |  | 2b. HOUR<br>6:50 A.M.   |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 13 1902   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>19 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>INDIANA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Annapolis  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Annapolis Convalescent Ctr. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD  |  | 13b. COUNTY<br>AA  |  | 13c. CITY OR TOWN<br>Annapolis  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>784 D Fairview Avenue   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOHN P HARRIS   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br>Louella HEATHCOCK  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>564-26-6443                          |  | 17. INFORMANT<br>ADDRESS<br>Robert L. Allard Same as #13   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Starvation - dehydration -<br>3320<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DOE TO, OR AS A CONSEQUENCE OF (b) Parkinson's Disease<br>DOE TO, OR AS A CONSEQUENCE OF (c) Senile Dementia -<br>Wang, Ys -<br>" " |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br>Osteoporosis - old pt. @ hip.   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/10/80 to 11/6/81, that (I) (we) last saw the deceased alive on 11/4/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>R. Brimhall MD  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br>11/6/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Rodney L. Brimhall, MD   |  |  |  | 22e. ADDRESS<br>1419 Forest Drive, Annapolis, MD  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |  | 23b. DATE<br>Nov. 7, 1981  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Ft. Lincoln   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brentwood PG MD                                   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>John M. Taylor & Sons   |  |  |  | ADDRESS<br>Annapolis, Md.   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 10 1981  |  | 25b. REGISTRAR'S SIGNATURE<br>James J. Parker  |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |                     |   |  |   |  |  |   |  |
|--|---------------------|---|--|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Lawrence XXX D. Anderson Jr</i>   |                     |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <i>11 22 1981</i>                 |   |  | 2b. HOUR<br><i>A.M.</i>  |   |  |
| 3. SEX<br><i>Male</i>  | 4. RACE<br><i>W</i> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <i>9 17 58</i>   | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <i>23</i> YRS.                    | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.   | 7c. DATE PRONOUNCED<br>DEAD <i>11 22 1981</i>                      | 7d. HOUR<br><i>P.M.</i>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Ohio</i>   |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>ANNE ARUNDEL CO MD.</i> |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Glen Burnie</i>  |                     | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>NORTH ARUNDEL HOSPITAL</i> |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Unemployed</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><i>Maryland</i>  |                     |   | 13b. COUNTY<br><i>Anne Arundel</i>                                     |   | 13c. CITY OR TOWN<br><i>Glen Burnie</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET ADDRESS<br><i>114 SE Main Avenue</i>   |                     |   | 21061  |   |  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Lawrence D. Anderson, Sr.</i>   |                     |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Shirley Temple</i> |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <i>NO</i>  |                     |   | 16b. SOCIAL SECURITY NO.<br><i>217-78-0083</i>                         |   | 17. INFORMANT<br>ADDRESS<br><i>Mrs. Shirley Bley 2017 Sulphur Spring Rd.</i>       |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Hanging</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>Last seen</i>  |                     |   |  |   |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |                     |   |  |   |  |  |   |  |
| 19a. DATE OF OPERATION   |                     |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                      |   |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                     |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)      |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |                     |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)            |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                  |  |   |  |
| 22a. I certify that I have changed the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                     |   |  |   |  |  |   |  |
| ACTUAL SIGNATURE<br><i>E. L. Hubbard</i>   |                     |   | TITLE (SPECIFY)<br><i>Deputy</i>                                       |   |  | DATE SIGNED<br><i>11.22.81</i>                                     |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <i>E. L. Hubbard</i>  |                     |   | ADDRESS<br><i>114 SE Main Avenue</i>                                   |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <i>Burial</i>   |                     |   | 23b. DATE<br><i>11/25/81</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Cedar Hill Cemetery</i>                   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Balto. Anne Arundel Md.</i>                    |  |
| 24. FUNERAL DIRECTOR<br>NAME <i>Mc Cully F.</i> ADDRESS <i>H. of Curtis Bay</i>  |                     |   | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 24 1981</i>                    |   | 25b. REGISTRAR'S SIGNATURE<br><i>Thomas J. Nathan</i>                              |  |   |  |
| 4200 Pennington Ave. Balto., Md. 21226   |                     |   |  |   |  |  |   |  |

Handwritten notes at the top of the page, including a date "Nov 11 1884" and some illegible text.

Handwritten notes in the middle section, including a signature "J. H. [illegible]" and other illegible text.

Handwritten notes at the bottom of the page, including a date "Nov 11 1884" and other illegible text.

BP

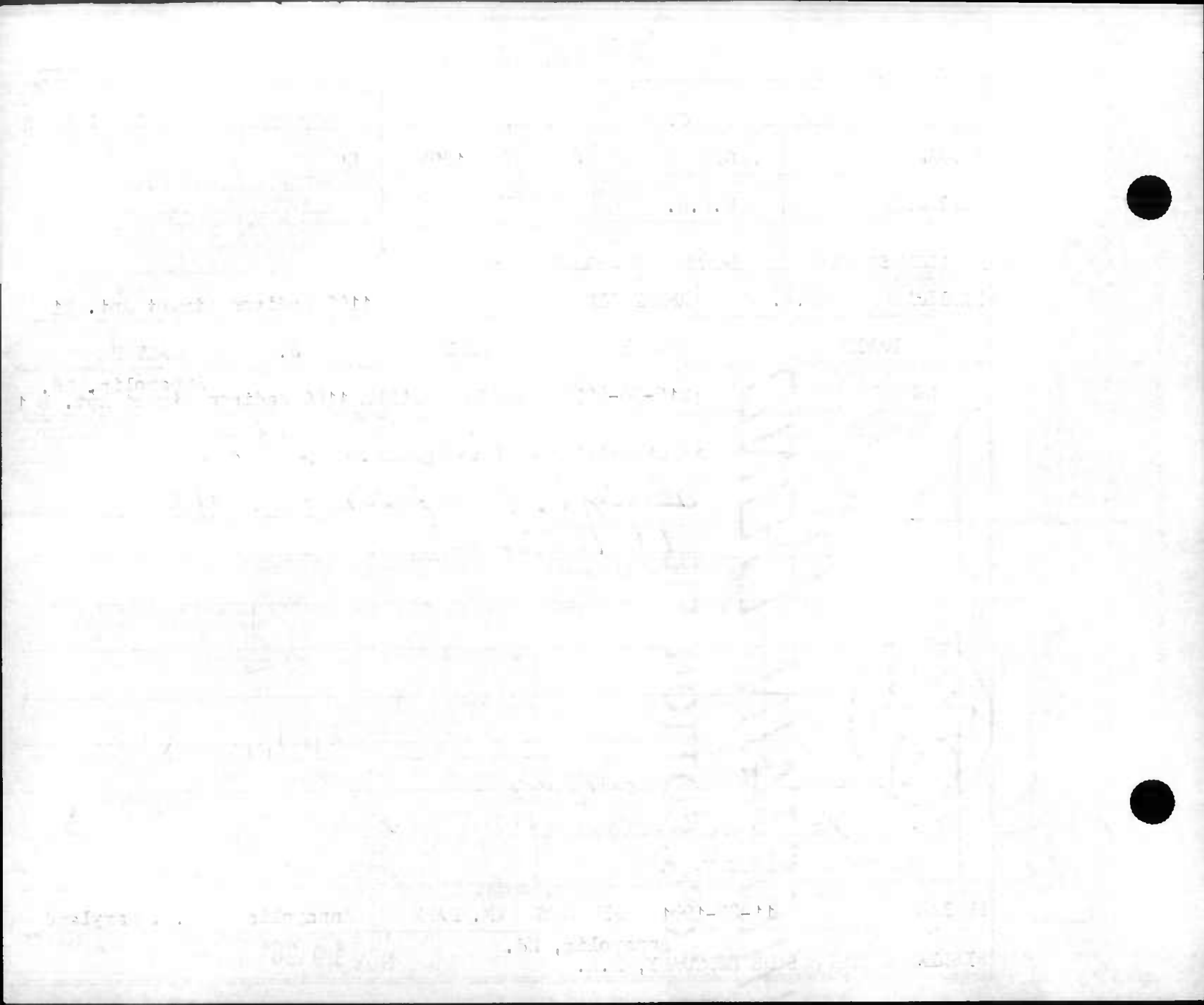
DHMH - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial/transfer permit. Then please remove carbon copiers. Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  | 8 1 2 7 3 6 7 |
|--|--|--|--|---|--|--|--|--|--|---------------|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |  |   |  |  |  | EST  |  |               |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MARIE J. ARTHUR</b>  |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOVEMBER 17, 1981</b>   |  | 2b. HOUR<br><b>9:15 M</b>  |  |               |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>NEGRO</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 6 1892</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>89</b>   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>  |  |               |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD.</b>   |  |  |  |               |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |               |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>A.A.</b>   |  | 13c. CITY OR TOWN<br><b>ANNAPOLIS</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/><br>13e. STREET ADDRESS<br><b>1100 Madison Street Apt. B1</b> |  |  |  |               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>DAVID DORSEY</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY J. EASTON</b>   |  |   |  | 16. ADDRESS<br><b>Annapolis, Md.<br/>1100 Madison Street Apt. B 1</b>  |  |  |  |               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>217-56-4776</b>   |  | 17. INFORMANT<br><b>CHARLES ARTHUR</b>  |  |  |  |  |  |               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>old age, septicaemia 2<sup>nd</sup> to</b><br><b>2765</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>urinary tract infection, D.M.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>diabetes</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |  |  |  |  |               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |  |  |  |  |               |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |               |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |               |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |               |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <b>11/17</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>11/17</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <b>Easton</b>   |  |  |  |   |  |  |  |  |  |               |
| 22b. SIGNATURE<br><b>Hamid A Towhidian, M.D.</b>   |  | 22c. DATE SIGNED<br><b>11/17/81</b>  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HAMID A. TOWHIDIAN, M.D.</b>  |  |  |  |  |  |               |
| 22e. ADDRESS<br><b>2334 MOUNTAIN ROAD<br/>PASADENA, MARYLAND 21122</b>   |  |  |  |   |  |  |  |  |  |               |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>   |  | 23b. DATE<br><b>11-20-1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PINELAWN MEM. PARK</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Annapolis A.A. Maryland</b>   |  |  |  |               |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b>   |  | 24b. ADDRESS<br><b>Annapolis, Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 19 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Easton</b>  |  |  |  |               |



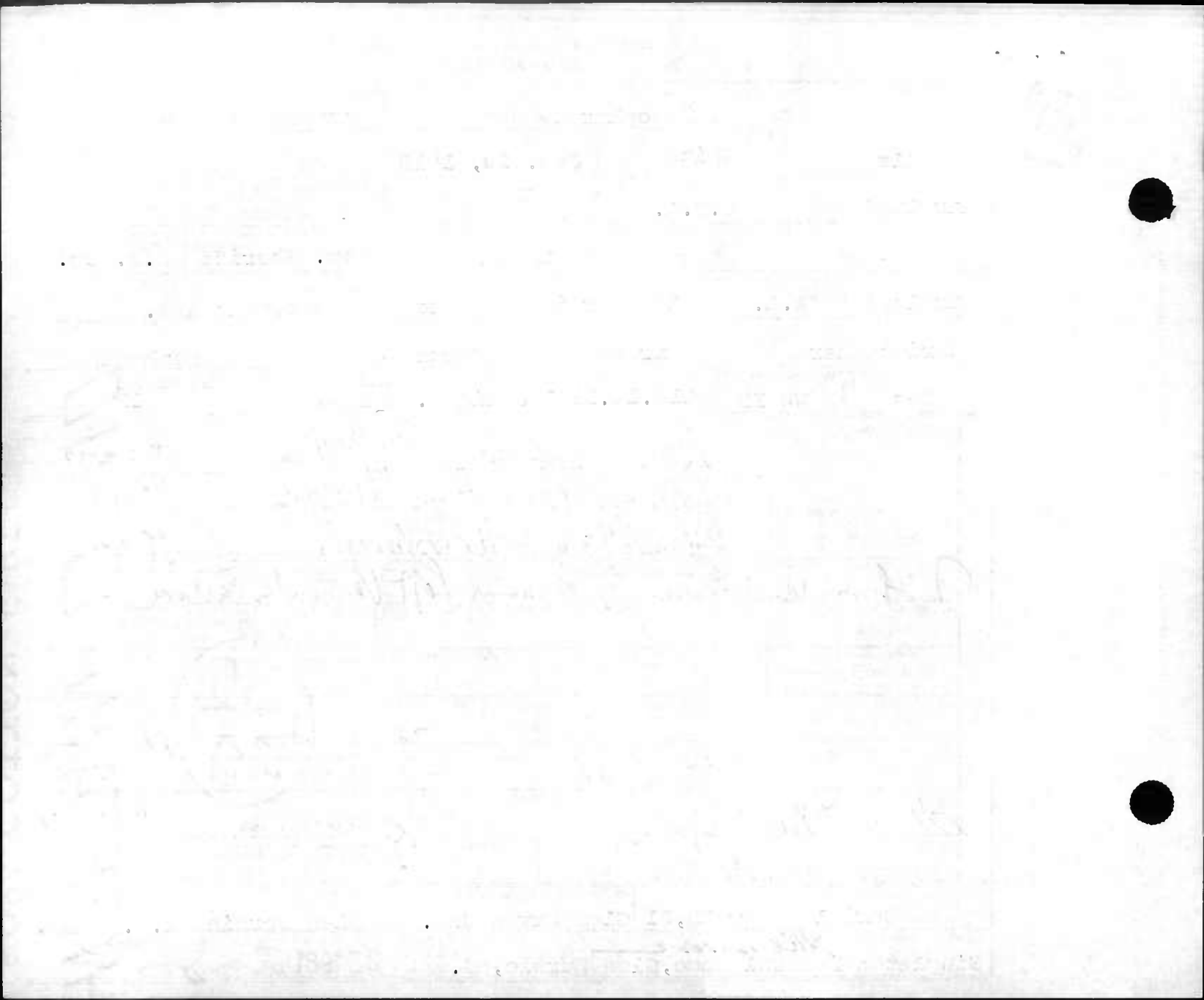
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  | 8 1 2 7 8 6 8 |        |
|--|--|--|--|---|--|--|--|--|--|---------------|--------|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  |  |  |  |  | REG. NO.      | E.S.T. |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>VICTOR Christopher BARNES</b>   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 21, 1981</b>  |  | 2b. HOUR<br><b>1635</b>  |  | P<br>M        |        |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 29, 1913</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>HOURS MIN.   |  |               |        |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY</b> MD  |  |  |  |               |        |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Dep. Sheriff</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>A.A. Co.</b>   |  |               |        |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>A.A.</b>   |  | 13c. CITY OR TOWN<br><b>Glen Burnie</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>8 Roosevelt Ave.</b>   |  |               |        |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Christopher Barnes</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Gertrude Fenhegan</b>   |  |  |  |  |  |               |        |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes WW II</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218.16.3303</b>   |  | 17. INFORMANT<br><b>Wife</b>  |  | ADDRESS<br><b>Same as 13</b>   |  |  |  |               |        |
| 18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Coronary Artery Aneurysm</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Generalized Atherosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Months</b><br><b>Years</b><br><b>Years</b> |  |  |  |   |  |  |  |  |  |               |        |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Chronic Pancreatic Disease &amp; Prolonged Left Ventricular Failure</b>   |  |  |  |   |  |  |  |  |  |               |        |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |               |        |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |               |        |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |               |        |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-18</b> 19 <b>79</b> , to <b>11-21</b> 19 <b>81</b> , that (I) (we) lost<br>saw the deceased alive on <b>11-18</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |  |  |               |        |
| 22b. SIGNATURE<br><b>Hilary O'Herlihy</b>  |  |  |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11-22-81</b>  |  |               |        |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HILARY O'HERLIHY, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>325 HOSPITAL DRIVE<br/>GLEN BURNIE, MARYLAND 21061</b>   |  |  |  |  |  |               |        |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Nov 25, 81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie A.A. Md.</b>  |  |  |  |               |        |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Singleton Funeral Home, Glen Burnie, Md.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 23 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Thomas J. Nathan</b>  |  |  |  |               |        |

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DHMH-16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Please 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 961-5311.

## MEDICAL CERTIFICATION

Item 7b G-563 1/6/32 GAB

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- STATE REGISTRAR **Jean Marie Barrard** REG. NO. **81 27869**

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST **Jean Marie Barrard**

2a. DATE OF DEATH MONTH DAY YEAR **11-29-81** 2b. HOUR **7:30 P.M.**

3. SEX **F** 4. RACE **Black** 5. DATE OF BIRTH MONTH DAY YEAR **12-10-31** 6. AGE (IN YEARS LAST BIRTHDAY) **49** YRS. MONTHS DAYS HOURS MIN.

7a. PLACE OF BIRTH (STATE OR FOREIGN COUNTRY) **Trinidad** 7b. CITIZEN OF WHAT COUNTRY? **Trinidad** 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH **ANNE ARUNDEL Co MD.**

10. CITY OR TOWN OF DEATH **Annapolis** 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) **ANNE ARUNDEL General** 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) **Clerk** 12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE **MD** 13b. COUNTY **A.A.** 13c. CITY OR TOWN **Annapolis** 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS **16A. Bens Drive**

14. FATHER'S NAME FIRST MIDDLE LAST **Robert Lassalle** 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST **UNKNOWN**

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) **NO** (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. **21450-8000** 17. INFORMANT ADDRESS **Robert Lassalle- 16A. Bens Drive**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **CANCER BREAST**  
**1749**  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  
(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF  
(c) \_\_\_\_\_

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) \_\_\_\_\_

19a. DATE OF OPERATION \_\_\_\_\_ 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED \_\_\_\_\_ 20a. AUTOPSY? YES ☐ NO ☐ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR **19** P.M. 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) \_\_\_\_\_

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) \_\_\_\_\_ 21f. LOCATION STREET CITY OR TOWN COUNTY STATE \_\_\_\_\_

22a. I certify that (I) (this hospital) attended the deceased from **11/29/81** to **11/29/81**, that (I) ~~was~~ last saw the deceased alive on **11/29/81**, 19\_\_\_\_\_, and that in (my) ~~own~~ opinion death occurred on the date and hour and from the causes stated above; (b) ~~was not~~ (did not) view the body after death.

22b. SIGNATURE **Stanley P. Watkins Jr.** DEGREE \_\_\_\_\_ ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED **11/30/81**

22d. PHYSICIAN'S NAME (TYPE OR PRINT) **STANLEY P. WATKINS** 22e. ADDRESS \_\_\_\_\_

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) **BURIAL** 23b. DATE **12-2-81** 23c. NAME OF CEMETERY OR CREMATORY **PINE LAWN** 23d. LOCATION CITY OR TOWN COUNTY STATE **Annapolis A.A. MD**

24. FUNERAL DIRECTOR **G.E. Hicks** ADDRESS **Annapolis-Md** 25a. DEC 8 1981 25b. BY REQUEST OF **Funeral Home**

9.29 13-13-11

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DHMH-16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

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FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

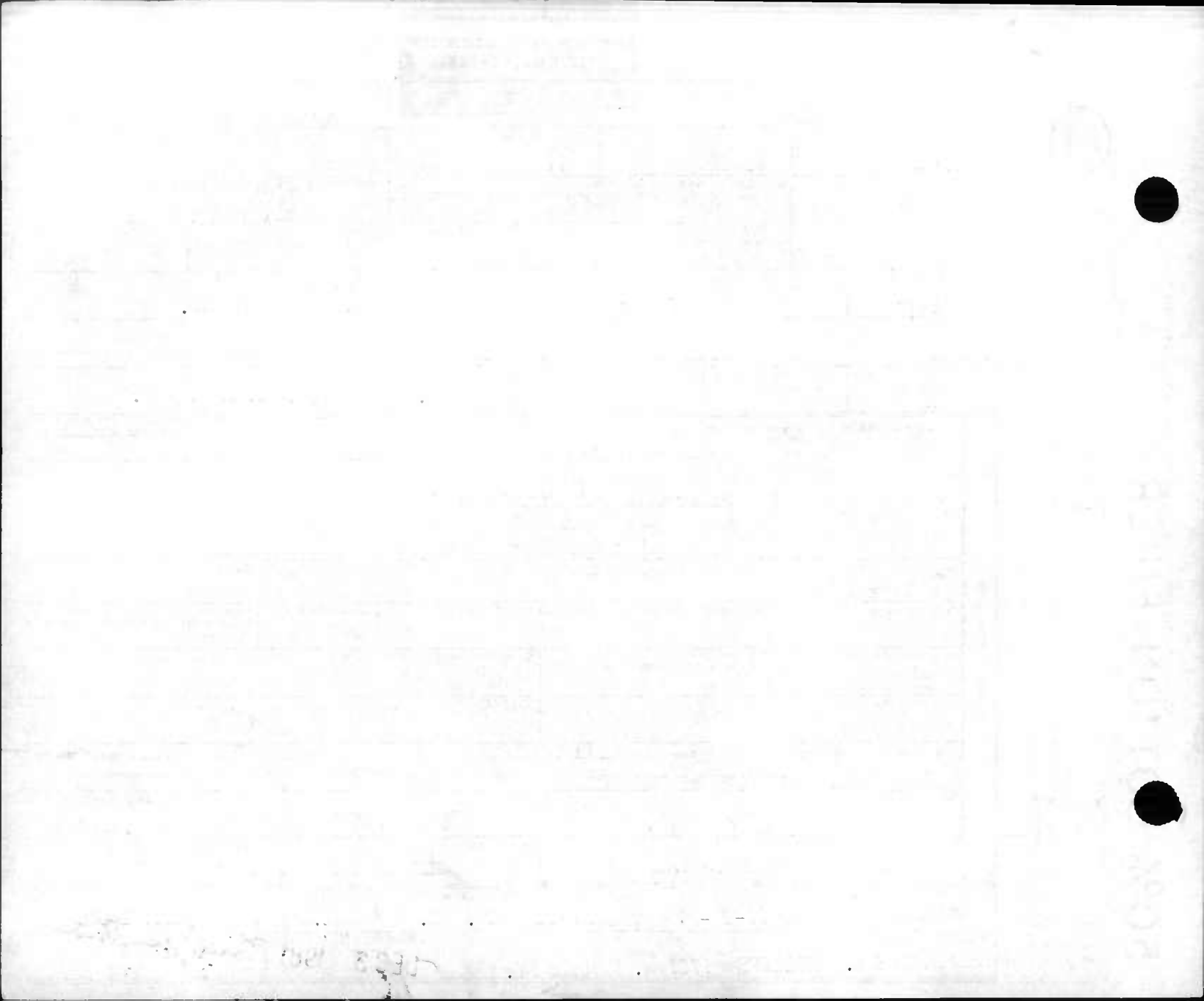
8 1 2 7 8 7 0

REG. NO.

EST

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JOSEPH BILLUP</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOVEMBER 19, 1981</b> |  |  | 2b. HOUR<br><b>5:35PM</b>  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>BLACK</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 19 81</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b><br>YRS. MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>VIRGINIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br><b>GLENN BURNIE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>THOMAS BILLUPS</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY BRIGGS</b>  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  |  |  |
| 17. INFORMANT<br><b>AUDREY S. MAY</b>  |  | ADDRESS<br><b>2261 MADISON AVE.</b>  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u><br><b>4860</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>Asphyxiation</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Pneumonia</u> |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>ASPHIX</b>   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/18</u> , 19 <u>81</u> , to <u>11/19</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>11/19</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                          |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Robert Kroopnick</u>  |  |  |  | DEGREE<br><u>MD</u>  |  | 22c. DATE SIGNED<br><u>11/20/81</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ROBERT KROOPNICK, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>205 BALTIMORE-ANNAPOLIS BLVD.<br/>GLEN BURNIE, MARYLAND 21061</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>   |  | 23b. DATE<br><b>11-25-81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WESTVIEW MEM. PK.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>ELIZABETH L. PHILLIPS 1721 N. MONROE ST.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 3 1981</b>   |  |  |  |

MEDICAL CERTIFICATION



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 8 7 1

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |  |  |
|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>Hubert H. Boyles</u>   |   | 2a. DATE OF DEATH<br>MONTH <u>11</u> DAY <u>2</u> YEAR <u>81</u>  |  | 2b. HOUR<br><u>8:30</u> AM   |
| 3. SEX<br><u>M</u> Male   | 4. RACE<br><u>W</u> Caucasian   | 5. DATE OF BIRTH<br>MONTH <u>2</u> DAY <u>6</u> YEAR <u>1899</u>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>82</u> YRS.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>West VA</u>   | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Anne Arundel</u> MD.                          |
| 10. CITY OR TOWN OF DEATH<br><u>Glen Burnie</u>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>NANCE CC</u> |   | 12. USUAL OCCUPATION<br>(GIVE WORK FOR MOST OF WORKING LIFE) <u>Coal Miner</u> |  |
| 13a. STATE<br><u>MD</u>   |   | 13b. CITY OR TOWN<br><u>Anne Arundel</u>  |  | 13c. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST <u>Abraham</u> MIDDLE <u>Boyles</u> LAST <u>Boyles</u>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <u>Molly</u> MIDDLE <u>NA</u> LAST <u>NA</u>  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <u>No</u>  |   | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><u>Hubert A. Boyles, Same as 13</u>                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Black lung, COPD, old tbc</u><br><u>5000</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>ASCVD, CHF</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Arteriosclerosis</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>fx of hip</u>  |   |   |  |  |
| 19a. DATE OF OPERATION<br><u>9/9/81</u>   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>fx of hip</u>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <u>19</u>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)           |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 12, 1980</u> to <u>Nov 2, 1981</u> , that (I) (we) lost<br>saw the deceased alive on <u>Oct 30, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |   |   |  |  |
| 22b. SIGNATURE<br><u>Mustafa C. Oz</u> DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |   |   |  | 22c. DATE SIGNED<br><u>11-2-81</u>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>MUSTAFA C. OZ</u>   |   | 22e. ADDRESS<br><u>605 B &amp; A Blvd Severna park</u>  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <u>Burial</u>  |   | 23b. DATE<br><u>Nov. 5, 81</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Simpson Cemetery</u>                            |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Flemington, W. VA</u>  |   | 23e. DATE REC'D. BY REGISTRAR<br><u>NOV 3 1981</u>  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>James S. Kirkley, Glen Burnie, MD</u>  |   | 25. REGISTRAR'S SIGNATURE<br><u>Francis Van Natten</u>  |  |  |

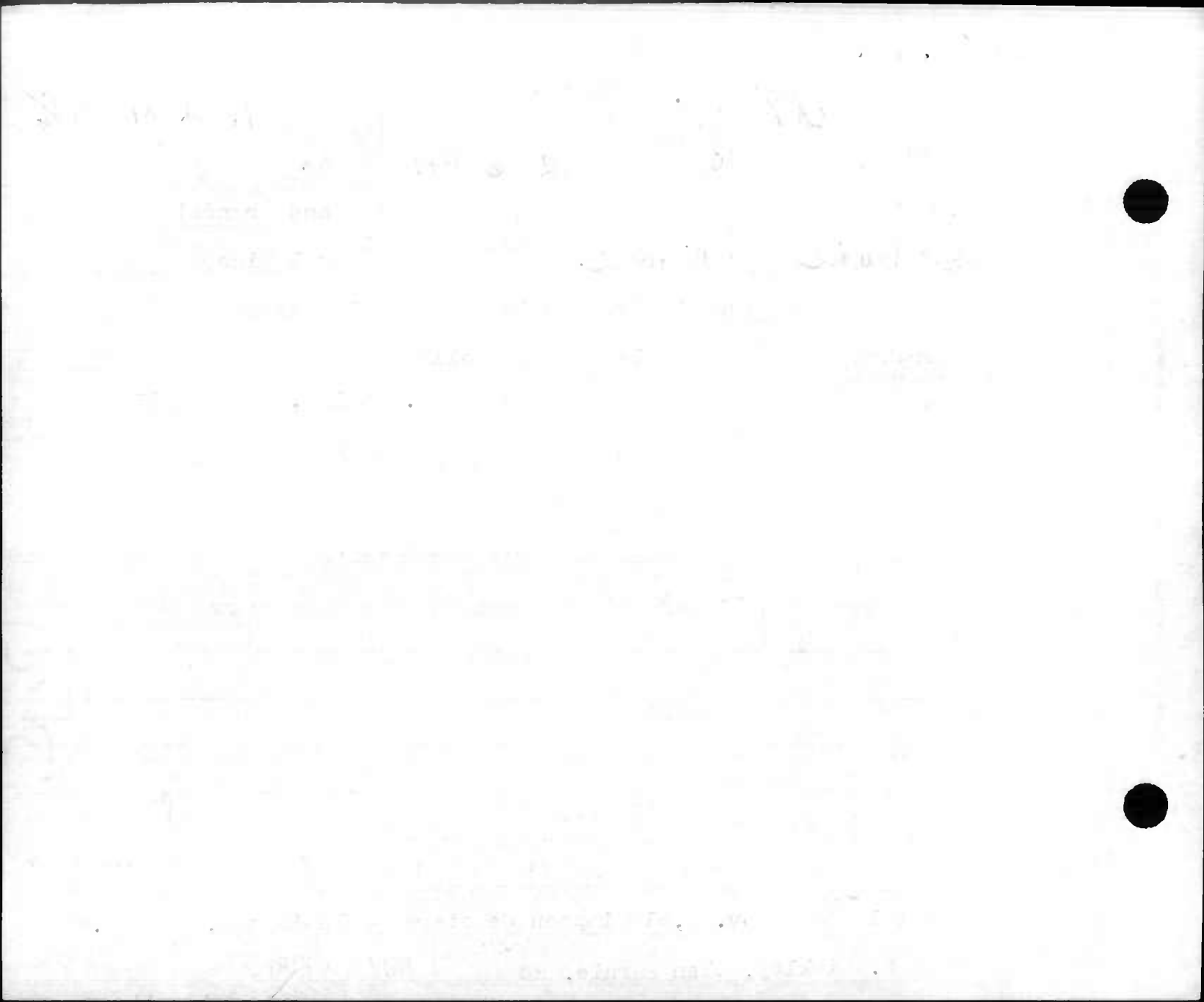
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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BP

DHMH - 16 50M 1/B1  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the body after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

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|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Odessa Day BROWN</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 24, 1981</b>   |   | 2b. HOUR<br><b>10:05 P</b>   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 10, 1899</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD.</b>  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                      |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Anne Arundel</b> 13c. CITY OR TOWN <b>Pasadena</b>  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 13e. STREET ADDRESS<br><b>1650 Wall Drive 21122</b>                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Rush</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rhoda Westfall</b>  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>Unknown</b>   | 17. INFORMANT ADDRESS<br><b>Mrs. J. Jesse Brown 1650 Wall Drive 21122</b>   |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for 18a, 18b, and 18c.<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br><b>4100</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF <b>hypertension &amp; coron. vascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Cholera</b><br>(b) (c) |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>day</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Shuman</b>   |  |   |   |   |  |
| 19a. DATE OF OPERATION<br><b>11/24/81</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/10/10</b> to <b>11/24/81</b> , that (I) (we) last saw the deceased alive on <b>11/24/81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) did not perform the autopsy after death.  |  |   |   |   |  |
| 22b. SIGNATURE<br><b>Anastacio E. Subong, M.D.</b>  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ANASTACIO E. SUBONG, M.D.</b>   |  |   | 22e. ADDRESS<br><b>7951 Oakwood Road<br/>Glen Burnie, Maryland 21061</b>  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>11/27/81</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Brick Church Cemetery Huttonsville</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>W. Va.</b>               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Mc Cully Funeral Home of So. Balto.<br/>130 C. Font Ave. Baltimore, Maryland 21230</b>   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 27 1981</b> 25b. REGISTRAR'S SIGNATURE<br><b>James VanNathan</b>                                  |   |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |  | 8 1 2 7 8 7 3   |  |                     |  |
|---|--|---|--|---|--|---|--|---|--|---|--|---------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  | 2b. HOUR            |  |
| FRANK BUSCH   |  |   |  |   |  |   |  | NOVEMBER 02, 1981   |  |   |  | 10:37A <sub>M</sub> |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan 13, 1911  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS<br>HOURS MIN.                           |  |                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ANNE ARUNDEL COUNTY MD.                                 |  |   |  |   |  |                     |  |
| 10. CITY OR TOWN OF DEATH<br>GLEN BURNIE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NORTH ARUNDEL HOSPITAL |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Ret. Longshoreman   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Shipping           |  |                     |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>Anne Arundel   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>8227 Ft. Smallwood Rd. 21226   |  |   |  |                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Emil Von Den Busch  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Louisa Schnieder   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>217-05-7401   |  | 17. INFORMANT ADDRESS<br>Mrs. Evelyn M. Busch same as 13  |  |   |  |                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ventricular Arrhythmia</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic Cardiovascular Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } <u>15 yrs with Congestive Heart Failure.</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>minutes |  |                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Hypertension, Aortic Stenosis, Insufficiency, Diabetes Mellitus.</u>   |  |   |  |   |  |   |  |   |  |   |  |                     |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 19c. AUTOPSY<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |   |  |                     |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |   |  |                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/1/80</u> to <u>11/2/81</u> , that (I) (we) last saw the deceased alive on <u>10/31/81</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |   |  |   |  |                     |  |
| 22b. SIGNATURE<br><u>Michael J. Garahy</u>  |  | DEGREE<br><u>M.D.</u>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |   |  | 22c. DATE SIGNED<br><u>11/02/81</u>   |  |   |  |                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MICHAEL GARAHY, M.D.   |  | 22e. ADDRESS<br>8206 FORT SMALLWOOD ROAD<br>BALTIMORE, MARYLAND 21226   |  |   |  |   |  |   |  |   |  |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>  |  | 23b. DATE<br><u>11/5/1981</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Glen Haven Mem. Park</u>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Glen Burnie Anne Arundel Md.</u>               |  |   |  |   |  |                     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Mc Cully F.H. Mountain &amp; Tick Neck Rds. 21122</u>  |  | ADDRESS<br><u>Pasadena, Md.</u>   |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><u>NOV 4 1981 Frances Jan. Nathan</u>   |  |   |  |   |  |   |  |                     |  |

BP \_\_\_\_\_



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 8 7-4

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |                           |   |  |  |  |
|--|--|---|--|---|---------------------------|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Elmer W. Butler Sr.</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-17-81</b> |   | 2b. HOUR<br><b>2:35</b> M |   |  |  |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9-12-19</b>  |                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN)<br><b>OR</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel Co</b> MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Annapolis</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ANNE ARUNDEL GENERAL</b>  |  |   |                           | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Machinist</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Railroad</b>             |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>a-a</b>   |  | 13c. CITY OR TOWN<br><b>Annapolis</b>   |                           | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  | 13e. STREET ADDRESS<br><b>1200 B + A Blvd</b>                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Walter E. Butler</b>  |  | 15. MOTHER'S NAME<br>FIRST MIDDLE LAST<br><b>Bertha M. Schwartz</b>   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>YES WW II - Army 218052080</b>                        |                           |   |  |  |  |
| 17. INFORMANT<br>NAME ADDRESS<br><b>Martha Corinne Butler - Olm</b>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>sq metastatic brain tumor</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>sq squamous cell carcinoma lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>chronic obstructive lung disease, coronary artery disease</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 mos</b> |  |   |                           |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>chronic obstructive lung disease, coronary artery disease</b>   |  |   |  |   |                           |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                           |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                           |   |  |  |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>11-13</b> , 19 <b>81</b> , to <b>11-17</b> , 19 <b>81</b> , that (2) (we) last saw the deceased alive on <b>11-17</b> , 19 <b>81</b> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/ we) (did) (did not) view the body after death. |  |   |  |   |                           |   |  |  |  |
| 22b. SIGNATURE<br><b>Dr. Mitchell</b>  |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                             |                           |   |  | 22c. DATE SIGNED<br><b>11-17-81</b>                              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Mitchell, MD</b>   |  | 22e. ADDRESS<br><b>16205 Ridge Ave</b>  |  | 23a. DATE REC'D. BY REGISTRAR   |                           |   |  |  |  |
| 23b. DATE<br><b>11-19-81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Nat. Mary</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Annapolis MD</b>   |                           | 23e. REGISTRAR'S SIGNATURE<br><b>Charles Jean Hartman</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Robert A. Baranco</b>   |  | 25. DATE REC'D. BY REGISTRAR<br><b>NOV 20 1981</b>  |  |   |                           |   |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

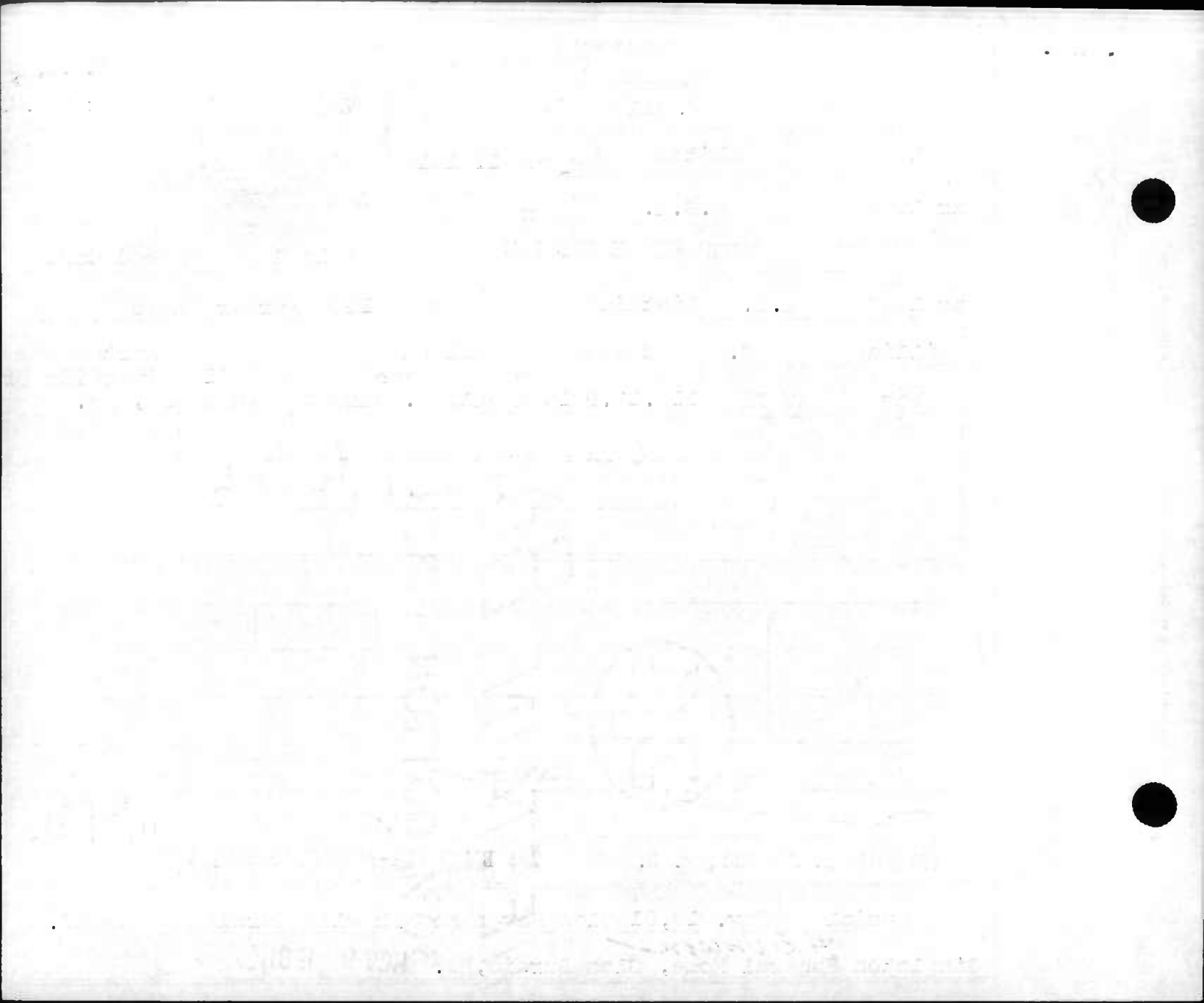
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH-16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 1 2 7 8 7 5  |  | REG. NO.  |  | E.S.T.   |  |
|---|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | 1. DECEASED NAME (TYPE OR PRINT)   |  | 2a. DATE OF DEATH   |  | 2b. HOUR   |  |
|   |  |   |  | WILLIAM Samuel CARSON  |  | NOVEMBER 6, 1981  |  | 5:00 P.M.  |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. IF UNDER 1 YEAR   |  |
| Male  |  | White   |  | MARCH 11 1918  |  | 63  |  | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  | 10. CITY OR TOWN OF DEATH                                      |  |
| Maryland  |  | U.S.A.  |  |  |  | ANNE ARUNDEL  |  | GLEN BURNIE  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION   |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |
| NORTH ARUNDEL HOSPITAL  |  |   |  | Self Emp   |  | Used Cars   |  |  |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |
| Maryland  |  | A.A.  |  | Linthicum  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 1604 Nursery Road  |  |
| 14. FATHER'S NAME   |  |   |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |  |  |
| William S. Carson   |  |   |  | Helena Kurtz   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  | ADDRESS   |  |  |  |
| Yes   |  | WW II   |  | 218.12.0215  |  | Son Ronald G. CARSON  |  | 610 Riverside Dr Pasadena, Md.                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:   |  |   |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u>  |  |   |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>met metastatic</u>  |  |   |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____  |  |   |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
|   |  | HOUR A.M. MONTH DAY YEAR  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION  |  |   |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE  |  |   |  | DEGREE   |  |   |  | 22c. DATE SIGNED   |  |
|   |  |   |  |  |  |   |  | 11/2/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  | 22e. ADDRESS   |  |   |  |  |  |
| PAVANJIT K. SAWHNEY, M. D.  |  |   |  | 205 BALTIMORE-ANNAPOLIS BOULEVARD, GLEN BURNIE, MARYLAND 21061   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | COUNTY STATE   |  |
| Burial  |  | Nov. 10, 81   |  | Glen Haven Mem Pk  |  | Glen Burnie   |  | AA Md.   |  |
| 24. FUNERAL DIRECTOR NAME   |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| Singleton Funeral Home, Glen Burnie, Md.  |  |   |  | NOV 9 1981   |  | Charles J. Nathan   |  |  |  |

MEDICAL CERTIFICATION



BP

DHMH-16 50M 1/B1  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrant, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 in our death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 8 1 2 7 8 7 6  |  |   |  |  |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE  |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR                                     |  |
| WILLIAM HENRY CAVE  |  |  |  |   |  |  |  | NOVEMBER 05, 1981   |  | 7:10 AM                                      |  |
| 3 SEX   |  | 4 RACE   |  | 5 DATE OF BIRTH   |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | 7 IF UNDER 1 YEAR   |  | 8 IF UNDER 24 HRS                            |  |
| Male  |  | White  |  | July 30, 1923   |  | 58 YRS.  |  | MONTHS DAYS   |  | HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |   |  |  |  |
| Virginia  |  | U.S.A.   |  |   |  | ANNE ARUNDEL COUNTY MD.  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |  |  |
| GLEN BURNIE   |  | NORTH ARUNDEL HOSPITAL   |  | Mechanic  |  | Automotive   |  |   |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS   |  |  |  |
| Maryland  |  | A. A.  |  | Severn  |  |  |  | 85 Gambrills Road   |  |  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |  |  |   |  |  |  |
| Noah  |  | Elisa Ann Funk   |  |   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17 INFORMANT  |  | ADDRESS  |  |   |  |  |  |
| yes   |  | WW-2   |  | 228-18-6344   |  | James A. Cave  |  | 8457 New Cut Road   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>M.I.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE  |  |  |  | DEGREE  |  |  |  | 22c. DATE SIGNED  |  |  |  |
| MARC A. KAPLAN, M.D.  |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                         |  |  |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS  |  |  |  |   |  |  |  |
| MARC A. KAPLAN, M.D.  |  |  |  | 325 HOSPITAL DRIVE GLEN BURNIE, MARYLAND 21061  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| Burial  |  | 11/9/1981  |  | Glen Haven Cem.   |  | Glen Burnie, A.A. Maryland   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME   |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| Raymond C. Fink   |  |  |  | Glen Burnie, Md.  |  |  |  | NOV 6 1981  |  |  |  |

Raymond C. Smith, Glen Durrill, Jr.,  
1101 Glen Haven Court, N.E., Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

81 27877

REG. NO.

|   |   |  |  |                            |  |
|---|---|--|--|----------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |   | 2a. DATE OF DEATH  |  | 2b. HOUR                   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   | 2a. DATE OF DEATH  |  | 2b. HOUR                   |  |
| BLANCHE E. CHAMBERS   |   | 11-18-81   |  | 6 A M                      |  |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                | 7. IF UNDER 1 YEAR         |  |
| Female  | NEGRO   | 11 22 04   | 76 YRS   | MONTHS DAYS HOURS MIN.     |  |
| 8. BIRTHPLACE (STATE OR FOREIGN)  | 9. BALTIMORE CITY OR COUNTY OF DEATH                          | 10. CITY OR TOWN OF DEATH  |  |                            |  |
| MARYLAND  | ANNE ARUNDEL COUNTY MD.                                       | ANNAPOLIS  |  |                            |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                            |  |
| ANNE ARUNDEL GENERAL HOSPITAL   |   |  |  |                            |  |
| 13a. STATE  | 13b. COUNTY   | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?                                       | 14. STREET ADDRESS         |  |
| MARYLAND  | A.A.  | ANNAPOLIS  | YES <input type="checkbox"/> NO <input type="checkbox"/>       | 823 Spa Road               |  |
| 15. FATHER'S NAME   | 16. MOTHER'S MAIDEN NAME                                      | 17. INFORMANT ADDRESS  |  |                            |  |
| GEORGE W. JOHNSON   | MAGGIE CARTER   | DOROTHY CHAMBERS 823 Spa Rd. Annapolis, Md.                                    |  |                            |  |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES?  | 18b. SOCIAL SECURITY NO.                                      | 19. INFORMANT ADDRESS  |  |                            |  |
| NO (YES, NO OR UNKNOWN)   | 212-32-3309   | DOROTHY CHAMBERS 823 Spa Rd. Annapolis, Md.                                    |  |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |   |  |  |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY   |   |  |  |                            |  |
| IMMEDIATE CAUSE (a) - Uremia.   |   |  |  |                            |  |
| DUE TO, OR AS A CONSEQUENCE OF  |   |  |  |                            |  |
| (b) renal failure   |   |  |  |                            |  |
| DUE TO, OR AS A CONSEQUENCE OF  |   |  |  |                            |  |
| (c) Pseudomonas Septicemia  |   |  |  |                            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |  |  |                            |  |
| Acute + chronic respiratory failure.  |   |  |  |                            |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED              | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                            |  |
|   |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                       | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>   | 21b. TIME OF INJURY   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |                            |  |
| OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   | HOUR A.M. MONTH DAY YEAR                                      |  |  |                            |  |
| (IF EITHER, NOTIFY MEDICAL EXAMINER)  | P.M. 19   |  |  |                            |  |
| 21d. INJURY OCCURRED  | 21e. PLACE OF INJURY  | 21f. LOCATION  |  |                            |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>   | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                | STREET CITY OR TOWN COUNTY STATE   |  |                            |  |
| AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   |  |  |                            |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 10/27/81 to 11/18/81, that (we) lost saw the deceased alive on 11/18/81, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we) did not view the body after death. |   |  |  |                            |  |
| 22b. SIGNATURE  |   | DEGREE   |  | 22c. DATE SIGNED           |  |
| Hye Clonious  |   |  |  | 11/18/81                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |   | 22e. ADDRESS   |  |                            |  |
| George P. Samaras   |   | 305 Ridgely Ave.   |  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL   | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY   | 23d. LOCATION  |                            |  |
| BURIAL  | 11-23-1981  | PINELAWN MEM. PARK   | Annapolis A.A. County Maryland                                 |                            |  |
| 24. FUNERAL DIRECTOR  |   | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE |  |
| Annapolis, Md.<br>WILLIAM REESE & SONS MORTUARY, P.A.   |   | NOV 19 1981  |  | [Signature]                |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1. FOR  
STATE  
REGISTRAR

REG. NO.

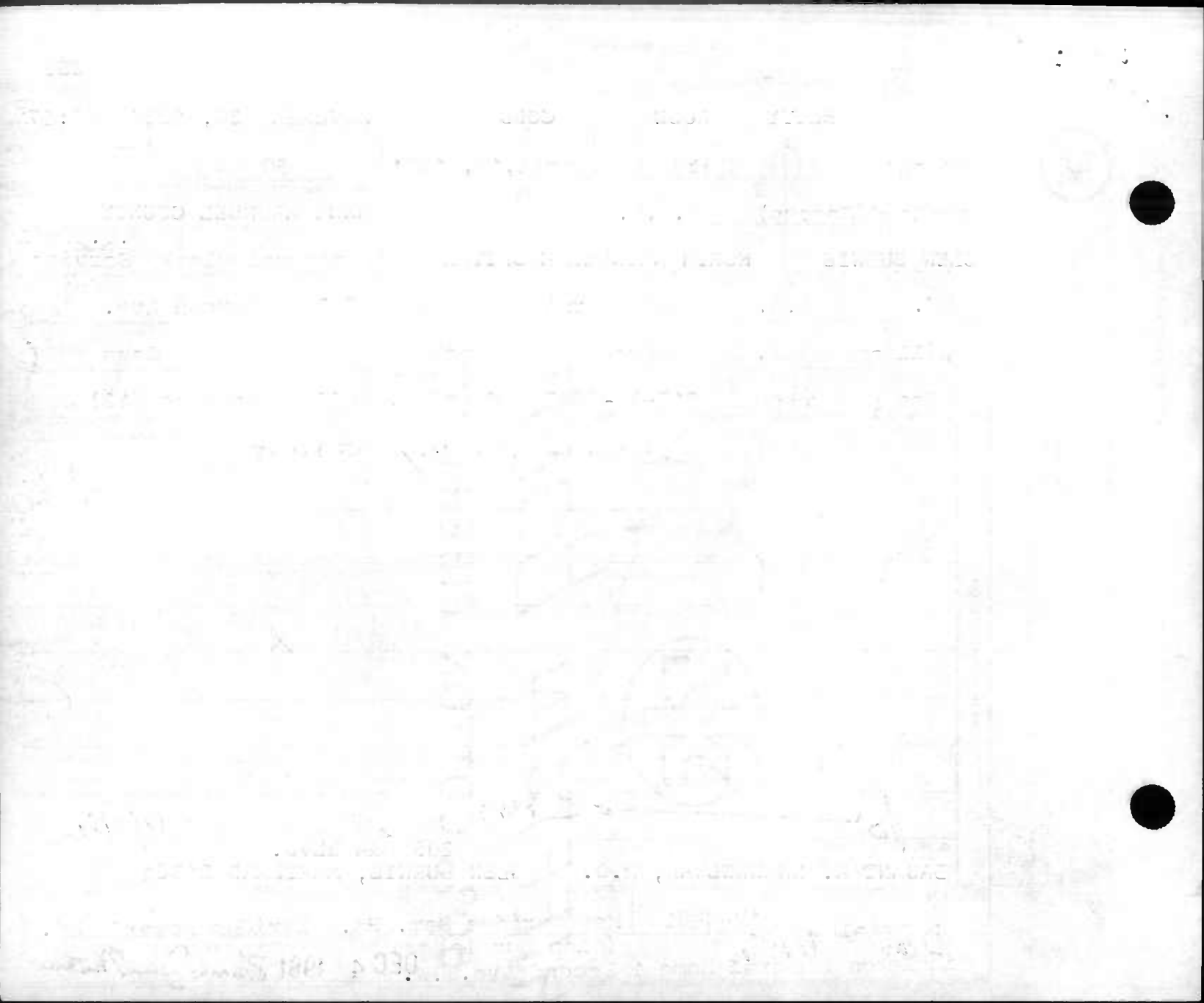
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|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>BETTY ROSE CODD</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 30, 1981</b>                            |   | 2b. HOUR<br>MIN.<br><b>10:17<sup>P</sup></b>   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April, 14, 1931</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>50</b>                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland (Jessup)</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD</b>                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Personnel Clerk</b> |   | 12b. KIND OF BUSINESS<br>INDUSTRY<br><b>Service</b>  |
| 13a. STATE<br><b>Md.</b>   |  |   | 13b. COUNTY<br><b>A.A.</b>   | 13c. CITY OR TOWN<br><b>Glen Burnie</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William B. Rice</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Evelyn Jess</b>                        |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>18-28-6943</b>   |  | 17. INFORMANT (Husband)<br>ADDRESS<br><b>Edward J. Codd (same as #13)</b>             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b><br><b>4275</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (If (we) did; did not) view the body after death.   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Basant K. Khandelwal</b>  |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>12/2/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BASANT K. KHANDELWAL, M.D.</b>   |  | 22e. ADDRESS<br><b>205 B&amp;A BLVD.<br/>GLEN BURNIE, MARYLAND 21061</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>12-4-81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Mem. Pk. Elkridge Howard Md.</b> |  |
| 24. FUNERAL DIRECTOR<br><b>Charles Singleton</b>   |  | ADDRESS<br><b>1 Second Ave. S</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 4 1981</b>                                    |  |
|  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Francis J. Nathan</b>  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

#5, Film G561 11/27/81 kam

1- FOR  
STATE  
REGISTRAR

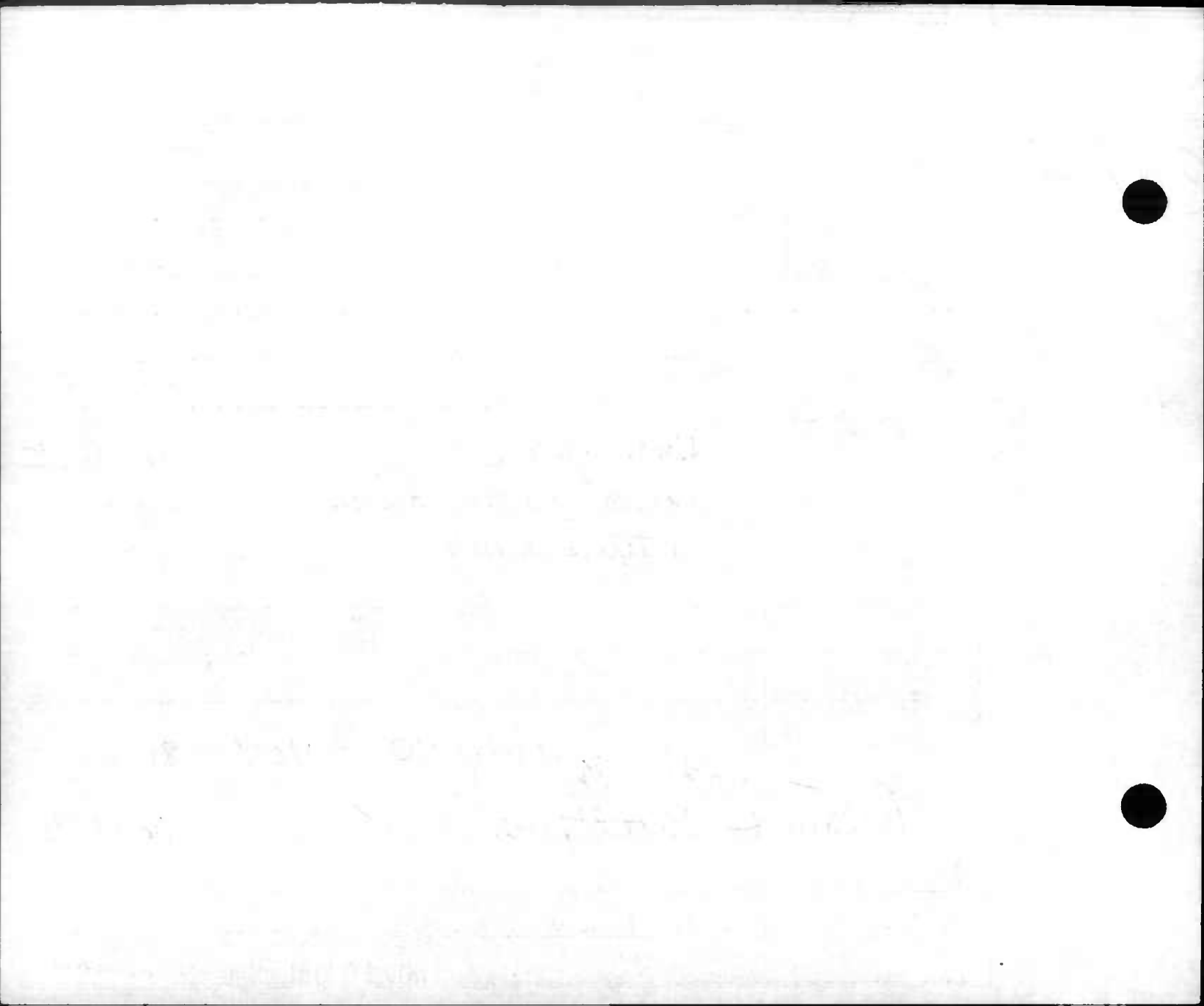
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 8 7 9

REG. NO.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Elsie Louise Colbert</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 14, 1981</b>                      |  | 2b. HOUR<br>M<br><b></b>   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 29, 1904</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b>                                   | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b></b>  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel Co.</b> MD.            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Annapolis</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Anne Arundel Gen. Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerk</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Sales</b>                              |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>  |  |   | 13b. COUNTY<br><b>A.A. Co.</b>   | 13c. CITY OR TOWN<br><b>Annapolis</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>James Pebworth</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Folford</b>             |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>577-18-6192</b>  | 17. INFORMANT<br>ADDRESS<br><b>Richard Miller 225 Cape St. John Rd.</b>          |  |  |
| 18. CAUSE OF DEATH - Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart failure</b><br>4149<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Coronary artery disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>arteriosclerosis</b> |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Immediate</b><br><b>yes.</b><br><b>yes.</b>                             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 81</b> to <b>Nov 81</b> , that (I) (we) last saw the deceased alive on <b>Sept 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>William H. Choate, M.D.</b>   |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>16 NOV 81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>Nov. 17, 1981</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Mem. Park</b>                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>T.A. Hardesty</b>   |  | ADDRESS<br><b>Annapolis Maryland 21401</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 16 1981</b>                            |  |
|  |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Nathan</b>  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |  | 8 1 2 7 8 8 0   |  |
|--|--|--|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |  |  |  |   |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MARtha E CURtis</b>  |  |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11 13 81</b>                       |  | 2b. HOUR<br><b>10<sup>55</sup> AM</b>  |  |   |  |
| 3. SEX<br><b>female</b>  |  | 4. RACE<br><b>Ne Gro</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>05 14 09</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>72</b>                         |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br><b></b>  |  | 7b. IF UNDER 24 HRS. HOURS MIN.<br><b></b>              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel MD</b>            |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Annapolis</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ANNE ARUNDEL GENERAL HOSPITAL</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b></b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b></b>   |  |   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |  |  | 13b. COUNTY<br><b>A.A.</b>   |  | 13c. CITY OR TOWN<br><b>EDGEWATER</b>                                     |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>3739 Oak Lane</b>             |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>HARRY CURTIS</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>CHARLOTTE SIMMS</b>   |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>219-28-8583</b>   |  | 17. INFORMANT ADDRESS<br><b>ELSIE BUTLER 3737 Oak Lane Edgewater, Md.</b> |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b><br><b>4100</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>ARTERIOSCLEROSIS</b><br>(c) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b></b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>ORGANIC BRAIN DISEASE</b>  |  |  |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>11/13/81</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b></b>  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>    |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                    |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b></b>  |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b></b>   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><b></b>  |  |   |  |  |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>11/5</b> 19 <b>75</b> , to <b>11/13</b> 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>11/5</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.   |  |  |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Donald C. Roane M.D.</b>  |  |  |  |  |  | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/13/81</b>                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Donald C. Roane M.D.</b>   |  |  |  |  |  | 22e. ADDRESS<br><b>134 Oronville Rd 20728</b>                             |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>   |  | 23b. DATE<br><b>11-18-1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HOPES CHURCH CEMETERY</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Edgewater A.A. Maryland</b> |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b>   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 17 1981</b>                       |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Heston</b>   |  |   |  |

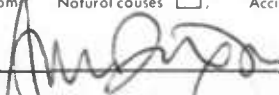
BP

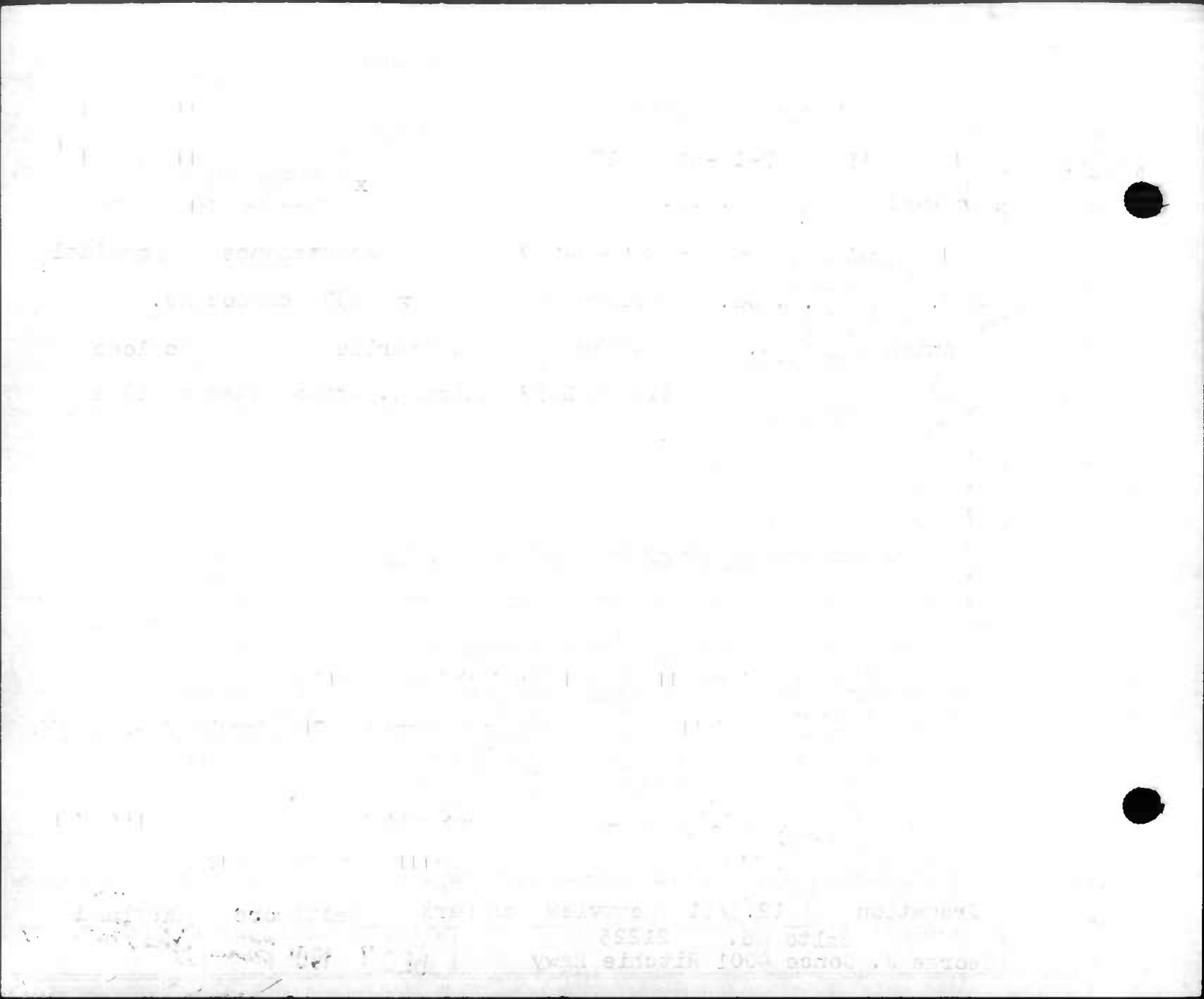


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITAL RECORDS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |                  |  |   |
|---|------------------|--|---|
| 1- STATE REGISTRAR  |                  | 27881  |   |
| 1. DECEASED NAME FIRST MIDDLE LAST<br>Timothy Louis Czako   |                  |  |   |
| 2a. DATE KNOWN OF DEATH   |                  | 2b. HOUR   |   |
| MONTH DAY YEAR<br>11 30 1981  |                  | M<br>1:02A   |   |
| 3. SEX<br>Male  | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7-16-54  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>27 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel County, MD.   |   |
| 10. CITY OR TOWN OF DEATH<br>Glen Burnie  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>North Arundel Hospital |   |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Maintenance  |                  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Hospital  |   |
| 13a. STATE<br>Md.   |                  | 13b. COUNTY<br>A.A. Co.  |   |
| 13c. CITY OR TOWN<br>Riviera Bch  |                  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                      |   |
| 13e. STREET ADDRESS<br>237 Kenwood Rd.  |                  |  |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Anton A. Czako   |                  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Catherine McGlone  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO   |                  | 16b. SOCIAL SECURITY NO.<br>213 84 2677  |   |
| 17. INFORMANT<br>Anton A. Czako   |                  | ADDRESS<br>same as 13 e  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hanging</u><br>9530<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                   |                  |  |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.   |                  |  |   |
| 19a. DATE OF OPERATION  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |
| 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                  |  |   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>12:xx 11 30 1981  |   |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Subject hanged self  |                  |  |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>jail  |   |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Hammonds Ferry Rd, Glen Burnie A.A.Co., Md.  |                  |  |   |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |  |   |
| ACTUAL SIGNATURE<br>   |                  | TITLE (SPECIFY)<br>M.D. Assistant MEDICAL EXAMINER   |   |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Ann M. Dixon, M.D.   |                  | DATE SIGNED<br>11/30/81  |   |
| ADDRESS<br>III Penn St. Balto., MD.   |                  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |                  | 23b. DATE<br>12/3/81   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Mem Park   |                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland   |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>George J. Gonc 4001 Ritchie Hgwy  |                  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 7 1981  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

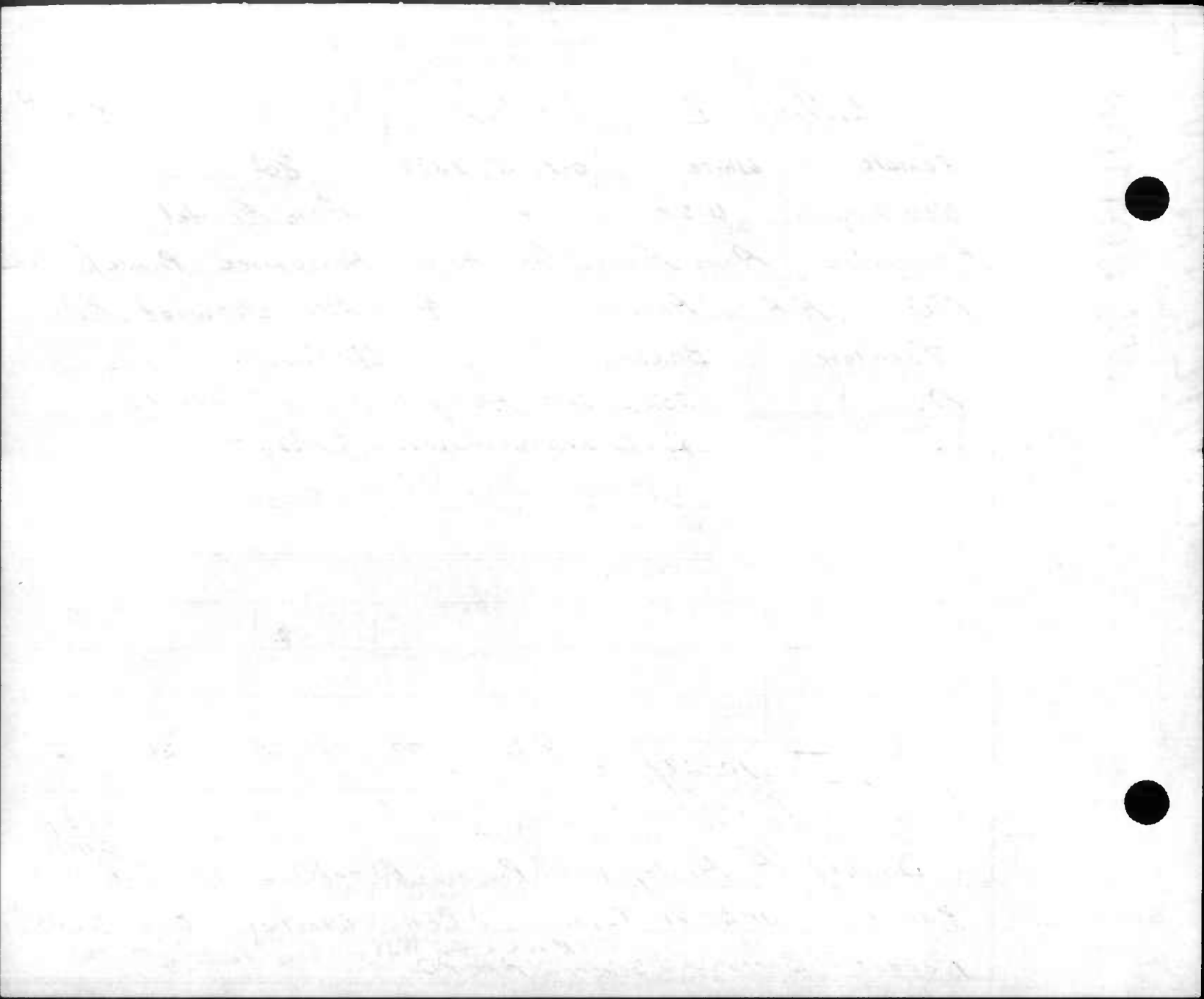
REG. NO.

8 1 2 7 8 8 2

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Lillian B. Danley</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11/21/81</b>                                |  | 2b. HOUR<br><b>5:43 P</b>  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 5, 1899</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Annapolis</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Anne Arundel Gen. Hosp.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>House work</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Private Residence</b>  |
| 13a. STATE<br><b>MD.</b>  |   |   | 13b. COUNTY<br><b>A.A.</b>  | 13c. CITY OR TOWN<br><b>Arnold</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Theodore Bowers</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>                       |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>232-20-362</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Harry M. Danley - Sec. 13</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio -</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Vascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>9-26</b> , 19 <b>79</b> , to <b>11-21</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>10-28</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Donald H. Hislop</b>   |   | 22c. DATE SIGNED<br><b>11/21/81</b>   |   | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Donald H. Hislop M.D.</b>  |  |
|   |   | 22e. ADDRESS<br><b>Robinson Rd. and Owens Way S.P. MD.</b>  |   | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>11-25-81</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenwood Cem.</b>  |  |
|   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Wheeling Ohio W. Va.</b>   |   | 23e. NOT RECD. BY REGISTRAR <b>NOV 23 1981</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Robert S. Barranco Severna Park MD.</b>  |   |   |   |  |  |

MEDICAL CERTIFICATION

29



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |  |   |
|---|--|--|---|--|---|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE KNOWN OF DEATH  |   | 2b. HOUR   |   |
| 1. DECEASED NAME (TYPE OR PRINT) <b>NOEM DERTOMASSIAN</b>   |  | 2a. DATE KNOWN OF DEATH <b>11 2 19 81</b>  |   | 2b. HOUR <b>9 PM</b>   |   |
| 3. SEX <b>Female</b>  | 4. RACE <b>White</b>   | 5. DATE OF BIRTH <b>Feb. 14 1900</b>   | 6. AGE (IN YEARS) <b>81 YRS.</b>  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Iran</b>   | 7b. CITIZEN OF WHAT COUNTRY? <b>Iran</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>A.P.C.C.</b>                              |  |   |
| 10. CITY OR TOWN OF DEATH <b>Annapolis</b>  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <b>Anne Arundel General</b> | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>homemaker</b>   | 12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>                                     |  |   |
| 13a. STATE <b>Md.</b>   | 13b. COUNTY <b>Ann Arundel</b>   | 13c. CITY OR TOWN <b>Annapolis</b>   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS <b>710 AMERICANA Dr.</b>                                     |   |
| 14. FATHER'S NAME <b>Aristes Gregorian</b>  | 15. MOTHER'S MAIDEN NAME <b>Firouzeh Hakopian</b>                                    | 17. INFORMANT <b>Peter Damave. Same as item 13</b>   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>  | 16b. SOCIAL SECURITY NO. <b>None</b>   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: <b>Coronary artery disease</b><br>IMMEDIATE CAUSE (a) <b>4149</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>4149</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>4149</b> |   |  |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |  |   |  |   |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                    |  |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>                          | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |  |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                          | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |   |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |  |  |   |  |   |
| ACTUAL SIGNATURE <b>E. Linhardt MD</b>  | TITLE (SPECIFY) <b>Deputy</b>  |  | DATE SIGNED <b>11-2-81</b>  |  | MEDICAL EXAMINER                        |
| EXAMINER'S NAME (TYPE OR PRINT) <b>E. LINHARDT MD</b>   | ADDRESS <b>Chesapeake Ave - Annapolis - MD</b>                                       |  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   | 23b. DATE <b>11/6/ 1981</b>  | 23c. NAME OF CEMETERY OR CREMATORY <b>Washington National Cem.</b>   | 23d. LOCATION CITY OR TOWN <b>Suitland Maryland</b>                               | 23e. COUNTY STATE  |   |
| 24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Son Inc.</b>   | 24b. DATE REC'D. BY REGISTRAR <b>NOV 6 1981</b>                                      |  | 24c. REGISTRAR'S SIGNATURE <b>James San Martin</b>                                |  |   |
| 5130 Wisc. Ave., N.W. Wash. D.C.  |  |  |   |  |   |

Handwritten notes and signatures on lined paper, including the date 11/15/1981 and the text "Washington National Bank".

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 8 8 4

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Helen B. Dmuchowski</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-26-81</b>  |  | 2b. HOUR<br>MIN.<br><b>4:35</b>  |
| 3. SEX<br><b>F</b>   | 4. RACE<br><b>W</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9-16-23</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b>   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Chicago, Ill.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel Co., MD.</b>                           |  |
| 10. CITY OR TOWN OF DEATH<br><b>Annapolis</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Anne Arundel Gen. Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Nurse</b>                | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>A.A. Co.</b> 13c. CITY OR TOWN <b>Annapolis</b>   |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>16 Silverwood Circle</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Michael Dmuchowski</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Victoria Holdinska</b>                      |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>422-212-770</b>  |   | 17. INFORMANT<br>ADDRESS <b>Stevensville, Md.</b><br><b>Eugene Deems, 301 Queens Anne Dr.,</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bilateral Cerebral dyspnea</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Metastasis of Fungal</b><br>DUE TO, OR AS A CONSEQUENCE OF<br><b>Adenocarcinoma of Lung</b> |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/25/81</b> to <b>11/26/81</b> , that (I) (we) last saw the deceased alive on <b>11/25/81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |   |  |  |
| 22b. SIGNATURE<br><b>George C. Samaras MD</b>  |  |   |   | 22c. DATE SIGNED<br><b>11/26/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>George C. Samaras</b>  |  |   |   | 22e. ADDRESS<br><b>205 Ridgely Ave. Annapolis, MD</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>cremation</b>   |  | 23b. DATE<br><b>11-27-81</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Crematory</b>                             |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood, Md.</b>  |  | 25a. DATE REG'D. BY REGISTRAR<br><b>NOV 27 1981</b>   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Beall Funeral Home, Annap., Md.</b>   |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. Walker</b>   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in your files after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 8 8 5

1. FOR  
STATE  
REGISTRAR

REG. NO.

EST

|  |  |   |  |  |                                 |  |  |
|--|--|---|--|--|---------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ROSE M. DOLAN</b> |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 9, 1981</b> |  | 2b. HOUR<br>A M<br><b>11:27</b> |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2-22-1913</b>   |                                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS HOURS MIN.<br><b>68</b>                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Penn.</b>                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD.</b>                       |  |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>AT HOME</b>  |                                 | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD.</b>   |  | 13b. COUNTY<br><b>MONT.</b>   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>  |                                 | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>PATRICK Dolan</b>                   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ann Costello</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>   |                                 | 16b. SOCIAL SECURITY NO.<br><b>188 01 4431</b>   |  |
| 17. INFORMANT<br><b>FAMILY RECORDS</b>   |  | 18. ADDRESS<br><b>BETHESDA, MD. 5528 WEST BARD AVE.</b>   |  | 19. STREET ADDRESS<br><b>5528 WEST BARD AVE.</b>   |                                 | 20. CITY OR TOWN<br><b>BETHESDA, MD.</b>   |  |

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **SEPSIS****7070**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) **MULTIPLE DECUBITUS ULCERS**

DUE TO, OR AS A CONSEQUENCE OF

(c)

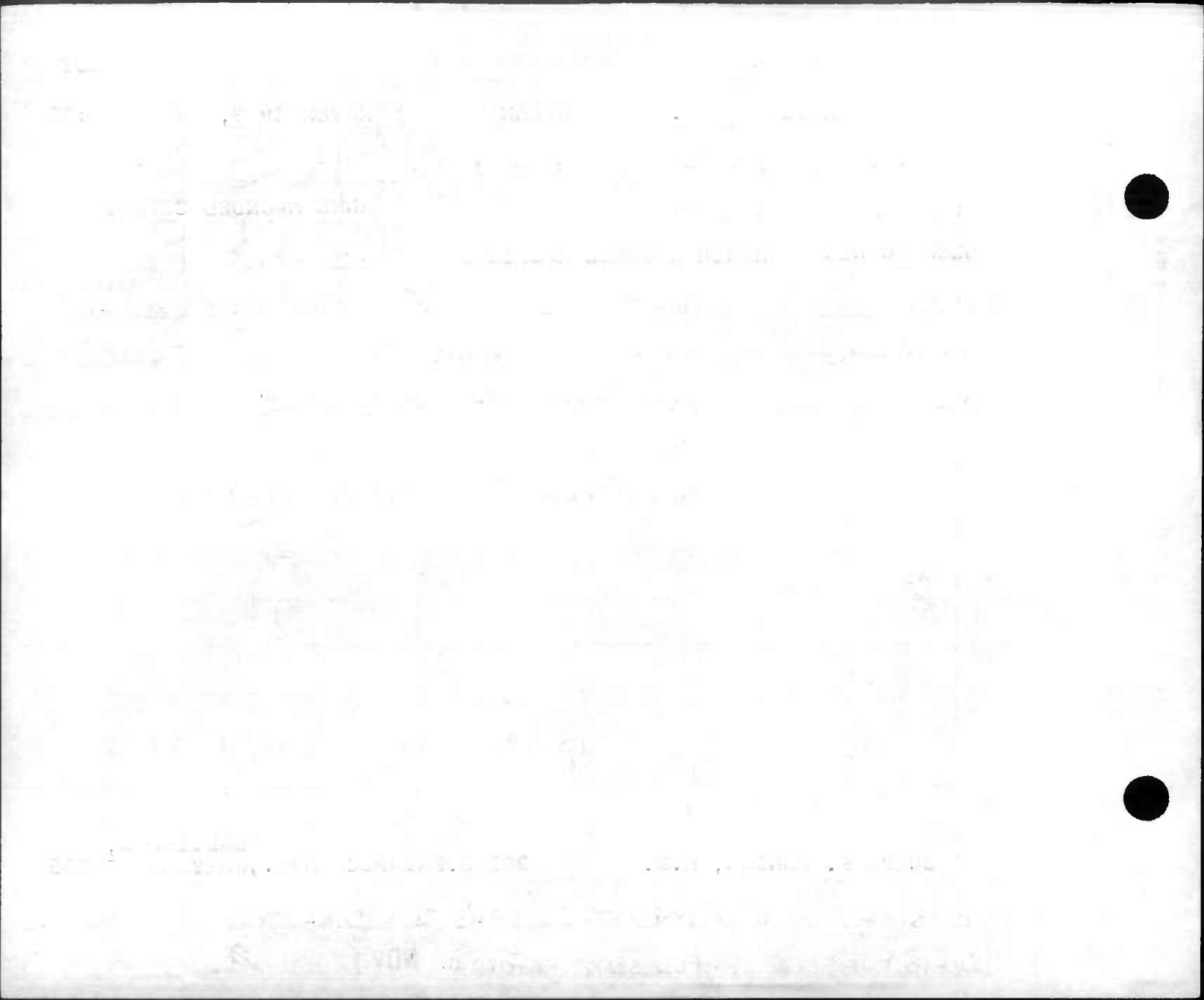
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

**Ca COLON**

MEDICAL CERTIFICATION

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                           |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11/9 81</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>11/9 81</b>            |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>203 E. PATAPSCO AVE., BALTIMORE, MARYLAND 21225</b> |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/9 81</b> to <b>11/9 81</b> , that (I) (we) last saw the deceased alive on <b>11/9 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>S. Munda</b>  |  |   |  | DEGREE<br><b>ATTENDING PHYSICIAN</b>  |  | 22c. DATE SIGNED<br><b>11/17/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SURYA P. MUNDRA, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>BALTIMORE, 203 E. PATAPSCO AVE., MARYLAND 21225</b>                                      |  |   |  |

|   |  |                                |  |   |  |   |  |
|---|--|--------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>                          |  | 23b. DATE<br><b>11-12-1981</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. JOSEPH'S CEM. SCRANTON</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Scranton Penn.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>EVANS FUNERAL CHAPEL 8800 HARFORD C.</b> |  |                                |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 12 1981</b>                     |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                    |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 8 8 6

FOR  
1. STATE  
REGISTRAR

REG. NO.

|   |   |   |  |  |   |
|---|---|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Elizabeth Marie Donahue</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 28, 1981</b>  |  | 2b. HOUR<br><b>11:45 PM</b>   |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MARCH, 06, 1934</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>47</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                                      |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel</b> MD.  |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Annapolis</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Anne Arundel Gen. Hosp.</b> | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  |   |
| 13a. STATE<br><b>Md.</b>  | 13b. COUNTY<br><b>Anne Arundel</b>  | 13c. CITY OR TOWN<br><b>Pasadena</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 13e. STREET ADDRESS<br><b>7675 Second St. 21122</b>                            |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert Benson Riddle</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Charlotte Augusta Smith</b>  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>216-32-2457</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Timothy R. Donahue same as 13</b>               |   |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral</b><br><b>15-39</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <b>initial volume decrease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                      |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1980</b> , 19____, to <b>11/28/81</b> , 19____, that (I) <del>was</del> last saw the deceased alive on <b>11/28</b> , 19____, and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did not) view the body after death.   |   |   |  |  |   |
| 22b. SIGNATURE<br><b>Stanley P. Watkins</b>   |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/28/81</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Stanley P. Watkins</b>  |   |   | 22e. ADDRESS<br><b>Cathedral St. Annapolis, Md. 21401</b>  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>12/2/1981</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Park</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie Anne Arundel Md.</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mc Cully F.H. Mountain &amp; Tick Neck Rds. 21122 Pasadena, Md.</b>  |   |   | 25a. DATE RECEIVED BY REGISTRAR<br><b>DEC 3 1981</b>   |  |   |
|   |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Thomas, Jan Thoma</b>   |  |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to give

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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|  |  |  |   |  |  |                           |  |  |  |
|--|--|--|---|--|--|---------------------------|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST  |   | 2a. DATE OF DEATH  |  | MONTH DAY YEAR            |  | 2b. HOUR                                     |  |
| Gertrude V. Dorsey   |  |  |   | Nov. 18, 1981  |  |                           |  | 7 45 A.M.                                    |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR           |  | IF UNDER 24 HRS                              |  |
| Female   | Black  | Dec. 20, 1934  |   | 46   |  | MONTHS DAYS               |  | HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |                           |  |  |  |
| MARYLAND   | U.S.A.   |  |   | Anne Arundel MD  |  |                           |  |  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |                           | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |  |
| Annapolis  | Anne Arundel Gen. Hosp.  |  |   |  |  |                           |  |  |  |
| 13a. STATE   | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS  |  |                           |  |  |  |
| Md.  | A.A.   | Annapolis  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 891 Chesterfield Rd.   |  |                           |  |  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |   | ADDRESS  |  |                           |  |  |  |
| ROBERT SMITH   |  | MARTHA HARRIED   |   | Annapolis, Md.   |  |                           |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS  |  |                           |  |  |  |
| NO   |  | 219-32-5604  |   | ROMAN DORSEY 891 Chesterfield Rd.  |  |                           |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:  |  |  |   |  |  |                           |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u>  |  |  |   |  |  |                           |  | MINS   |  |
| 1749 DUE TO, OR AS A CONSEQUENCE OF (b) <u>BREAST CANCER</u>   |  |  |   |  |  |                           |  | MONTHS                                       |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |   |  |  |                           |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |   |  |  |                           |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |  |  |                           |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 20a. AUTOPSY?  |                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |
|  |  |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |                           | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |                           |  |  |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |   |  |  |                           |  |  |  |
|  |  | P.M. 19  |   |  |  |                           |  |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY   |   | 21f. LOCATION  |  |                           |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]   |   | STREET   |  | CITY OR TOWN COUNTY STATE |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>5-</u> , 19 <u>80</u> , to <u>11-18</u> , 19 <u>81</u> , that (1) (we) lost saw the deceased alive on <u>11-18</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |  |   |  |  |                           |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |   | 22c. DATE SIGNED   |  |                           |  |  |  |
| <u>Ronald Pickett</u>  |  | MD   |   | 11-18-81   |  |                           |  |  |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |                           |  |  |  |
| RONALD PICKETT   |  |  |   |  |  |                           |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)  |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION             |  |  |  |
| BURIAL   |  | 11-21-1981   |   | LAKEMOUNT CEMETERY   |  | CITY OR TOWN COUNTY STATE |  |  |  |
|  |  |  |   |  |  | Davidsonville Maryland    |  |  |  |
| 24. FUNERAL DIRECTOR NAME  |  | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE   |  |                           |  |  |  |
| WILLIAM REESE & SONS MORTUARY, P.A.  |  | NOV 19 1981  |   | <u>James J. Nathan</u>   |  |                           |  |  |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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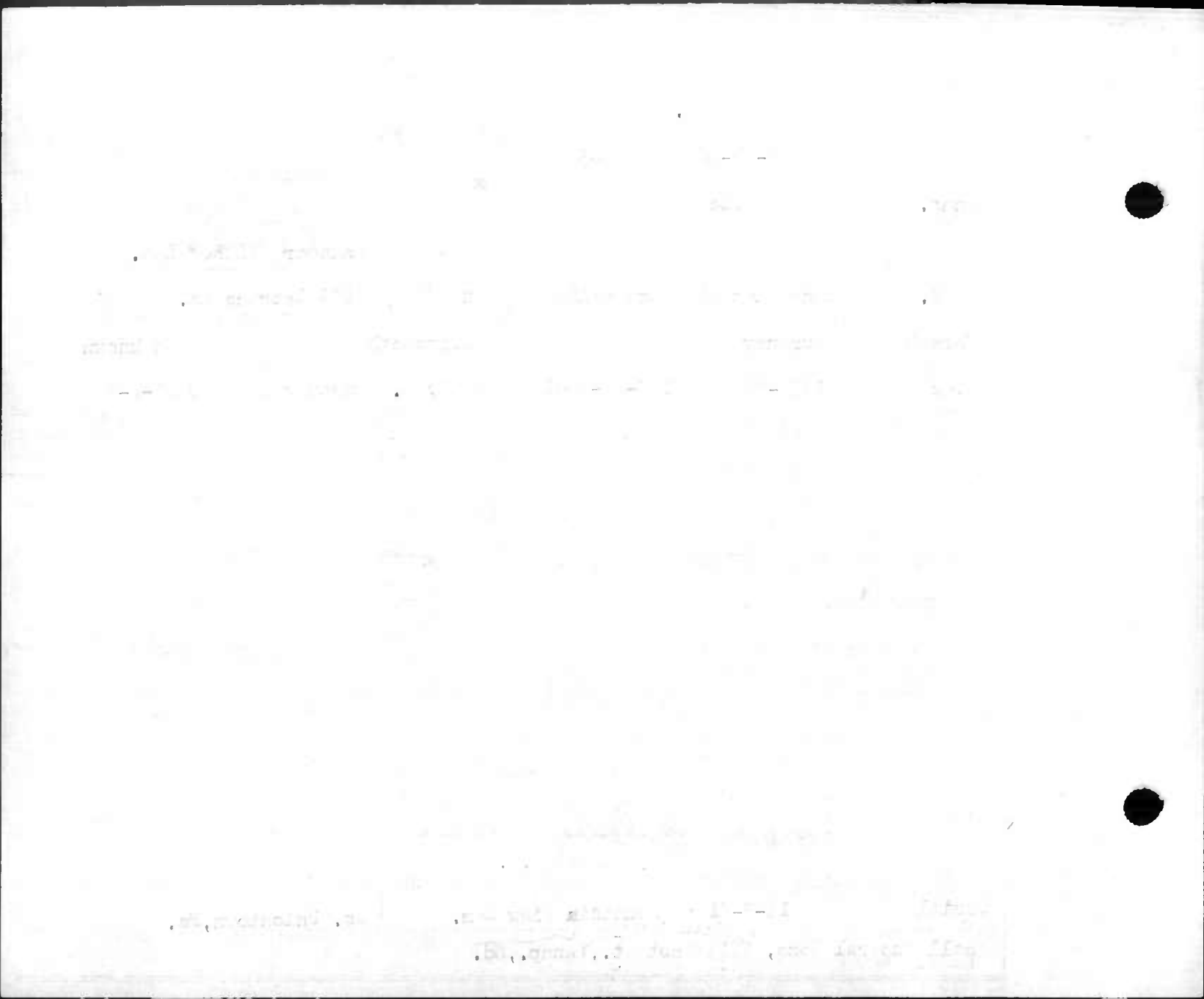
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |  |              |  |  |  |                          |  |   |  |   |  |                                     |  |          |  |  |  |  |  |
|---|--|--------------|--|--|--|--------------------------|--|---|--|---|--|-------------------------------------|--|----------|--|--|--|--|--|
| 1- FOR STATE REGISTRAR  |  |              |  |  |  |                          |  |   |  | 27888   |  |                                     |  |          |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |              |  |  |  |                          |  |   |  | 2a. DATE KNOWN OF DEATH ESTIMATED                           |  |                                     |  |          |  |  |  |  |  |
| JOSEPH E. DURANEY   |  |              |  |  |  |                          |  |   |  | 11-3-81   |  |                                     |  |          |  |  |  |  |  |
| 3 SEX   |  | 4 RACE       |  | 5 DATE OF BIRTH  |  | 6 AGE (IN YEARS)         |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.  |  | 7c. DATE PRONOUNCED DEAD            |  | 2b. HOUR |  |  |  |  |  |
| male  |  | white        |  | 9-24-36  |  | 45 YRS.                  |  | MONTHS  |  | DAYS  |  | 11-3-81                             |  | 6:47 PM  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |              |  | 7b. CITIZEN OF WHAT COUNTRY?                             |  |                          |  | 8 MARRIED   |  |   |  | 9 BALTIMORE CITY OR COUNTY OF DEATH |  |          |  |  |  |  |  |
| Penna.  |  |              |  | Usa  |  |                          |  | NEVER MARRIED   |  |   |  | Anne Arundel County MD              |  |          |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |              |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  |                          |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |          |  |  |  |  |  |
| Annapolis   |  |              |  | Anne Arundel General Hospital                            |  |                          |  | Manager VITRO* LAB.   |  |   |  |                                     |  |          |  |  |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |              |  |  |  |                          |  |   |  |   |  |                                     |  |          |  |  |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? |  | 13e. STREET ADDRESS   |  |   |  |                                     |  |          |  |  |  |  |  |
| Md.   |  | Anne Arundel |  | Annapolis  |  | YES                      |  | 3109 Catrina La.  |  |   |  |                                     |  |          |  |  |  |  |  |
| 14 FATHER'S NAME  |  |              |  |  |  |                          |  |   |  | 15. MOTHER'S MAIDEN NAME                                    |  |                                     |  |          |  |  |  |  |  |
| Joseph Duraney  |  |              |  |  |  |                          |  |   |  | Elizabeth Un known  |  |                                     |  |          |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |  |              |  |  |  |                          |  |   |  | 17. INFORMANT ADDRESS                                       |  |                                     |  |          |  |  |  |  |  |
| yes   |  |              |  |  |  |                          |  |   |  | Cathy L. Duraney same as 13-a-e                             |  |                                     |  |          |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |              |  |  |  |                          |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                |  |                                     |  |          |  |  |  |  |  |
| PART I DEATH WAS CAUSED BY:   |  |              |  |  |  |                          |  |   |  |   |  |                                     |  |          |  |  |  |  |  |
| IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease   |  |              |  |  |  |                          |  |   |  |   |  |                                     |  |          |  |  |  |  |  |
| 4292  |  |              |  |  |  |                          |  |   |  |   |  |                                     |  |          |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |              |  |  |  |                          |  |   |  |   |  |                                     |  |          |  |  |  |  |  |
| (b)   |  |              |  |  |  |                          |  |   |  |   |  |                                     |  |          |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |              |  |  |  |                          |  |   |  |   |  |                                     |  |          |  |  |  |  |  |
| (c)   |  |              |  |  |  |                          |  |   |  |   |  |                                     |  |          |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  |              |  |  |  |                          |  |   |  |   |  |                                     |  |          |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |              |  |  |  |                          |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |                                     |  |          |  |  |  |  |  |
|   |  |              |  |  |  |                          |  |   |  |   |  |                                     |  |          |  |  |  |  |  |
| 20 AUTOPSY?   |  |              |  |  |  |                          |  |   |  |   |  |                                     |  |          |  |  |  |  |  |
| YES   |  |              |  |  |  |                          |  |   |  | NO  |  |                                     |  |          |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |  |              |  |  |  |                          |  |   |  | 21b. TIME OF INJURY   |  |                                     |  |          |  |  |  |  |  |
|   |  |              |  |  |  |                          |  |   |  | HOUR A.M. MONTH DAY YEAR                                    |  |                                     |  |          |  |  |  |  |  |
|   |  |              |  |  |  |                          |  |   |  | P.M. 19   |  |                                     |  |          |  |  |  |  |  |
| 21d. INJURY OCCURRED  |  |              |  |  |  |                          |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  |                                     |  |          |  |  |  |  |  |
| WHILE AT WORK   |  |              |  |  |  |                          |  |   |  | STREET  |  |                                     |  |          |  |  |  |  |  |
| CITY OR TOWN  |  |              |  |  |  |                          |  |   |  | COUNTY STATE  |  |                                     |  |          |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy   |  |              |  |  |  |                          |  |   |  | Inspection  |  |                                     |  |          |  |  |  |  |  |
| death resulted from: Natural causes   |  |              |  |  |  |                          |  |   |  | Undetermined manner   |  |                                     |  |          |  |  |  |  |  |
| TITLE (SPECIFY)   |  |              |  |  |  |                          |  |   |  | DATE SIGNED   |  |                                     |  |          |  |  |  |  |  |
| Margarita A. Korell, M.D.   |  |              |  |  |  |                          |  |   |  | 11-4-81   |  |                                     |  |          |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  |              |  |  |  |                          |  |   |  | ADDRESS   |  |                                     |  |          |  |  |  |  |  |
| 111 Penn Street   |  |              |  |  |  |                          |  |   |  |   |  |                                     |  |          |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL   |  |              |  |  |  |                          |  |   |  | 23b. DATE   |  |                                     |  |          |  |  |  |  |  |
| Burial  |  |              |  |  |  |                          |  |   |  | 11-7-81   |  |                                     |  |          |  |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY  |  |              |  |  |  |                          |  |   |  | 23d. LOCATION   |  |                                     |  |          |  |  |  |  |  |
| Mountain View Cem.  |  |              |  |  |  |                          |  |   |  | So. Uniontown, Pa.  |  |                                     |  |          |  |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |              |  |  |  |                          |  |   |  | 25a. DATE REC'D BY REGISTRAR                                |  |                                     |  |          |  |  |  |  |  |
| Beall Funeral Home, 1212 West St., Annap., Md.  |  |              |  |  |  |                          |  |   |  | 25b. REGISTRAR'S SIGNATURE                                  |  |                                     |  |          |  |  |  |  |  |
|   |  |              |  |  |  |                          |  |   |  | Nov 9 1981  |  |                                     |  |          |  |  |  |  |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

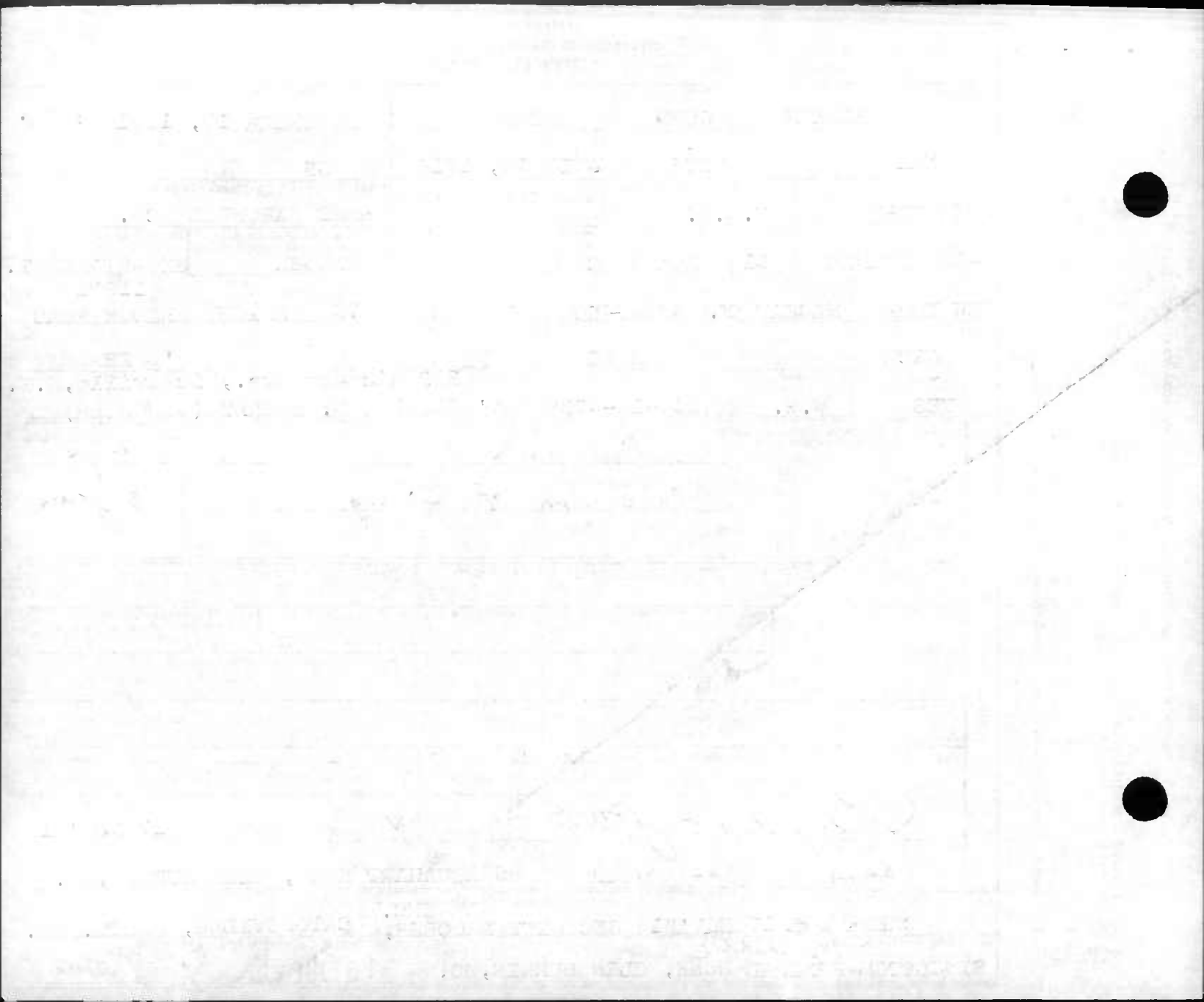
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 8 8 9

|  |  |  |                                      |  |  |
|--|--|--|--------------------------------------|--|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |                                      | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 2a. DATE OF DEATH  |                                      | 2b. HOUR   |  |
| ROBERT JOHN EBERLY   |  | NOVEMBER 17, 1981  |                                      | 6:03 A   |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)      | IF UNDER 1 YEAR  |  |
| MALE   | WHITE  | JULY 24, 1916  | 65 YRS.                              | IF UNDER 24 HRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |  |
| NEW YORK   | U.S.A.   |  | ANNE ARUNDEL CO. MD.                 |  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY    |  |  |
| GLEN BURNIE  | 314 KLAGG COURT  | SINGER   | ENTERTAINMENT                        |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   | 13b. CITY OR TOWN  | 13c. INSIDE CITY LIMITS?   | 13d. STREET ADDRESS                  |  |  |
| NEW YORK   | NASSAU CO. GREATNECK   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 75 KNIGHT BRIDGE ROAD                |  |  |
| 14. FATHER'S NAME  | 15. MOTHER'S MAIDEN NAME   | 16. ADDRESS  |                                      |  |  |
| JACK EBERLE  | PEGGY O'BRIEN  | 303 Richard Ave., Hicksville, N.Y.   |                                      |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  | 16b. SOCIAL SECURITY NO.   | 17. INFORMANT  |                                      |  |  |
| YES  | W.W. II  | MS' FLORINE M. EBERLY (DAUGHTER)   |                                      |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:  |  |  |                                      |  |  |
| IMMEDIATE CAUSE (a) <u>Pneumonia</u>   |  |  |                                      |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of Lung</u>  |  |  |                                      |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 1/2 years</u>  |  |  |                                      |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |                                      |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                      | 20a. AUTOPSY?  |  |
|  |  |  |                                      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |                                      |  |  |
|  |  | P.M. 19  |                                      |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY   |                                      | 21f. LOCATION  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                                      | CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-14</u> , 19 <u>81</u> , to <u>17</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>17</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.) |  |  |                                      |  |  |
| 22b. SIGNATURE   |  |  |                                      | 22c. DATE SIGNED   |  |
| <u>Sandy clark of md</u>   |  |  |                                      | 17 NOV '81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |                                      | 22e. ADDRESS   |  |
| SANDY C. DOH. M.D.   |  |  |                                      | 95 AQUAHART ROAD, GLEN BURNIE, MD.   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |                                      | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| CREMATION  |  | 17 NOV '81   |                                      | SECURITY PROCESS, INC.   |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |                                      | 25b. REGISTRAR'S SIGNATURE   |  |
| NAME   |  | ADDRESS  |                                      |  |  |
| SINGLETON FUNERAL HOME, GLEN BURNIE, MD.   |  | NOV 19 1981  |                                      | <u>James J. Nathan</u>   |  |

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

E.S.T.

|   |   |   |   |  |  |  |
|---|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MARGARET C. LAST ECKSTINE  |   |   | 2a. DATE OF DEATH<br>MONTH NOVEMBER 10, 1981<br>DAY<br>YEAR                     |  | 2b. HOUR<br>6:11 A.M.                        |  |
| 3. SEX<br>Female  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH May 4, 1902<br>DAY<br>YEAR  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ANNE ARUNDEL COUNTY MD.  |  |  |
| 10. CITY OR TOWN OF DEATH<br>GLEN BURNIE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NORTH ARUNDEL HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Sales clerk |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>H/ Kohn |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Anne Arundel 13c. CITY OR TOWN Pasadena   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 13e. STREET ADDRESS<br>877 Woods Rd. 21122   |  |  |
| 14. FATHER'S NAME<br>FIRST Francis MIDDLE Dufano LAST Long  |   | 15. MOTHER'S MAIDEN NAME<br>MIDDLE Della LAST Long  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) No   |   | 16b. SOCIAL SECURITY NO.<br>--- 214-22-4479   |   | 17. INFORMANT<br>ADDRESS<br>Herbert B. Eckstine, Sr. Same as #13   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a): C V A<br>4360<br>DUE TO, OR AS A CONSEQUENCE OF:<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) Aortic aneurysm<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) |   |   |   |  |  |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):<br>Diabetes   |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/9/81 to 11/10/81, and that (I) (we) (our) opinion of death occurred on the date and hour and from the causes stated.  |   |   |   |  |  |  |
| 22b. SIGNATURE<br>Jorge B. Ramirez, M.D.  |   | DEGREE<br>M.D.  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>11/10/81   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |   | 23b. DATE<br>11/13/1981   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem. Park   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Glen Burnie, Anne Arundel, Md.   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Mc Cully F.H. Mtn. & Tick Neck Rds., Pasadena, Md.  |   | ADDRESS<br>21122  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 12 1981   |  |  |
| 25b. REGISTRAR'S SIGNATURE<br>Frances Santherton  |   |   |   |  |  |  |

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR Items 18a, 20a., 20b.<br>1- STATE REGISTRAR Film#G560 a1 12-1-81  |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 1 2 7 8 9 1  |  |   |  |
|---|--|--|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH   |  |   |  | 2b. HOUR   |  |   |  |
| James P Fox   |  |  |  | November 12 81  |  |   |  | 1352 M   |  |   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>CAU   |  | 5. DATE OF BIRTH<br>Jan. 23, 1926   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>55   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Mass.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel County MD.                                 |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Ft. Meade  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Kimbrough Army Community Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Chaplain (Catholic) US Army |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  | 13e. STREET ADDRESS<br>1828 Montreal St., Severn, Md.                                |  |   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Anne Arundel  |  | 13c. CITY OR TOWN<br>Severn   |  |   |  |  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Francis Fox   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Kathryn Clark  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW II & Korea 034-14-9459  |  | 17. INFORMANT ADDRESS<br>From Medical SEC William Huurman<br>Records - KACH, FGGM, MD           |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>4254 IMMEDIATE CAUSE (a) <u>Cardiomyopathy</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____  |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)                  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>Rose Marie Hendrix  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br>12 Nov 81  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Rose Marie Hendrix, D.O. CPT, MC   |  |  |  | 22e. ADDRESS<br>Kimbrough Army Community Hospital, Ft. Meade, Md.   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>11-16-81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlington National Cem.   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arlington Va.                          |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME Marshall's Funeral Home<br>4217 9th St NW, Washington, D.C.  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 17 1981  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>Francis J. Nathan                                      |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  | 81 27892 |  |
|---|--|--|--|---|--|--|--|--|--|----------|--|
| 1 - FOR<br>STATE<br>REGISTRAR   |  | REG. NO.   |  |   |  |  |  |  |  |          |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><u>Allen Edward Frieman</u>   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><u>11-29-81</u>   |  | 2b. HOUR<br><u>11:55 am</u>  |  |          |  |
| 3. SEX<br><u>male</u>   |  | 4. RACE<br><u>white</u>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>April 20, 1917</u>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>64</u> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Baltimore Md.</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Anne Arundel Co. MD.</u>  |  |  |  |          |  |
| 10. CITY OR TOWN OF DEATH<br><u>Annapolis</u>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Anne Arundel General Hosp.</u> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>barber</u>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>self employed</u>  |  |          |  |
| 13a. STATE<br><u>Md.</u>  |  | 13b. COUNTY<br><u>A.A. Co.</u>   |  | 13c. CITY OR TOWN<br><u>Galesville</u>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><u>4822 Church Lane</u>   |  |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>Meyer L. Frieman</u>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Sophie Sklar</u>  |  |  |  |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>yes</u>  |  | 16b. SOCIAL SECURITY NO.<br><u>1939-1940 213-16-3352A</u>  |  | 17. INFORMANT<br>ADDRESS<br><u>Selma Florence Frieman 4822 Church Lane Galesville, Md. 20765</u>  |  |  |  |  |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myelocytic Leukemia</u><br><u>2051</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <u>Polycthemia Vera</u><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST<br>(c) <u>20 years</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |  |  |  |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |  |  |          |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <u>19</u>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  |  |  |  |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |          |  |
| 22a. I certify that I (this hospital) attended the deceased from <u>April 8, 1981</u> to <u>Nov 8, 1981</u> , that I (we) lost <u>Nov 4, 1981</u> saw the deceased alive on <u>Nov 4, 1981</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |  |  |          |  |
| 22b. SIGNATURE<br><u>MD Weintraub</u>   |  |  |  | DEGREE<br><u>MD</u>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>11/30/81</u>  |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS  |  |  |  |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>  |  | 23b. DATE<br><u>11/30/81</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Woodfield Cemetery</u>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Galesville, Md.</u>   |  |  |  |          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Hardesty Funeral Home 12 Ridgely Ave. Ann. Md.</u>   |  |  |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>DEC 1 1981</u>   |  |  |  |          |  |
|   |  |  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Thomas J. [Signature]</u>   |  |  |  |          |  |

MEDICAL CERTIFICATION



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

E.S.T.

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>EDNA G. GARDNER  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 5, 1981                       |   | 2b. HOUR<br>3:25A M  |
| 3. SEX<br>Female  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 24, 1896  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS.  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ANNE ARUNDEL COUNTY MD.                                 |  |
| 10. CITY OR TOWN OF DEATH<br>GLEN BURNIE  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NORTH ARUNDEL HOSPITAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home   |  |
| 13a. STATE<br>Md.   |   | 13b. COUNTY<br>Anne Arundel   | 13c. CITY OR TOWN<br>Pasadena   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br>2317 Mountain Rd. 21122   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Thomas Myers  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Unknown  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>215-30-1633   |   | 17. INFORMANT<br>ADDRESS<br>William S. Gardner same as 13                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u><br>4960<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Severe Chronic Obstructive Lung Dis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Myocardial Infarction</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u> |   |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Coronary Heart Failure</u>  |   |   |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-15-87</u> to <u>11-5-87</u> that (I) (we) last saw the deceased alive on <u>11-5-87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |   |   |  |
| 22b. SIGNATURE<br><u>[Signature]</u>  |   | DEGREE<br><u>[Signature]</u>  |   | 22c. DATE SIGNED<br>11-5-87   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JACK I. STERN, M.D., P.A.  |   | 22e. ADDRESS<br>300 HOSPITAL DRIVE, SUITE 135<br>GLEN BURNIE, MARYLAND 21061  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>11/9/1981  | 23c. NAME OF CEMETERY OR CREMATORY<br>Pleasant Valley Cem.  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Westminster Carroll Md.                           |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Mc Cully F. H.  |   | ADDRESS<br>Pasadena, Md.<br>Mountain & Tick Neck Rds. 21122   |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 10 1981  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.DHMH - 16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH                               |  |   |  |                                  |  |                                   |  |   |  | 8 1 2 7 8 9 4                   | EST |  |  |   |  |   |  |                                      |  |
|--|--|---|--|----------------------------------|--|-----------------------------------|--|---|--|---------------------------------|-----|--|--|---|--|---|--|--------------------------------------|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH                                       |  | 2b. HOUR                         |  | 3. SEX                            |  | 4. RACE   |  | 5. DATE OF BIRTH                |     | 6. AGE   |  | 7. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 2a. DATE OF DEATH                                       |  | 2b. HOUR                         |  | 3. SEX                            |  | 4. RACE   |  | 5. DATE OF BIRTH                |     | 6. AGE   |  | 7. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |
| Louie (Lutok) GARVIN   |  | NOVEMBER 6, 1981  |  | 3:58 M.                          |  | Male                              |  | White   |  | Dec. 19 1922                    |     | 58 YRS.  |  | USA   |  | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | ANNE ARUNDEL COUNTY, MD.             |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION            |  | 12b. KIND OF BUSINESS OR INDUSTRY |  | 13a. STATE  |  | 13b. COUNTY                     |     | 13c. CITY OR TOWN                                |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |  | 14. FATHER'S NAME                    |  |
| GLEN BURNIE  |  | NORTH ARUNDEL HOSPITAL                                  |  | Foreman                          |  | Manufacturing                     |  | MD  |  | AA                              |     | Glen Burnie                                      |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 52 B4 Glen Ridge Rd.  |  | Lutoc Garvin                         |  |
| 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?            |  | 16b. SOCIAL SECURITY NO.         |  | 17. INFORMANT                     |  | 18. CAUSE OF DEATH  |  | 19a. DATE OF OPERATION          |     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  |  | 21a. ACCIDENT WAS UNDERLYING         |  |
| (NA)   |  | Yes   |  | 232-44-9763                      |  | Helen M. Garvin, Same as 13       |  | PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CVA<br>4360<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) Arteriosclerotic<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) AS NO - |  |                                 |     |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | OR CONTRIBUTING CAUSE OF DEATH       |  |
| 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED                                |  | 22a. SIGNATURE                   |  | 22b. ADDRESS                      |  | 22c. DATE SIGNED  |  | 23a. BURIAL, CREMATION, REMOVAL |     | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY                                  |  | 23d. LOCATION   |  | 24. FUNERAL DIRECTOR                 |  |
| HOUR A.M. MONTH DAY YEAR   |  | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | Jorge B Ramirez MD               |  | 7845 Oakwood Road                 |  | 11/7/81   |  | Burial                          |     | 10 Nov 81  |  | Crownsville Veterans  |  | Crownsville AA MD   |  | James S. Kirkley, Glen Burnie, MD    |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY                                    |  | 21f. LOCATION                    |  | 25a. DATE REC'D. BY REGISTRAR     |  | 25b. REGISTRAR'S SIGNATURE  |  | 26a. DATE OF OPERATION          |     | 26b. CONDITION FOR WHICH OPERATION WAS PERFORMED |  | 26c. AUTOPSY?   |  | 26d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?  |  | 27a. ACCIDENT WAS UNDERLYING         |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)          |  | STREET CITY OR TOWN COUNTY STATE |  | NOV 10 1981                       |  | James S. Kirkley  |  |                                 |     |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | OR CONTRIBUTING CAUSE OF DEATH       |  |
| 27b. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) view the body after death |  | 27c. SIGNATURE  |  | 27d. ADDRESS                     |  | 27e. DATE SIGNED                  |  | 27f. REGISTRAR'S SIGNATURE  |  | 27g. DATE SIGNED                |     | 27h. REGISTRAR'S SIGNATURE                       |  | 27i. DATE SIGNED  |  | 27j. REGISTRAR'S SIGNATURE  |  | 27k. DATE SIGNED                     |  |
| 11/6/81  |  | Jorge B Ramirez MD                                      |  | 7845 Oakwood Road                |  | 11/7/81                           |  | James S. Kirkley  |  | 11/7/81                         |     | James S. Kirkley                                 |  | 11/7/81   |  | James S. Kirkley  |  | 11/7/81                              |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |   |   |   |  | 8 1 2 7 8 9 5                        |  |
|--|---|---|---|--|--------------------------------------|--|
| 1. FOR STATE REGISTRAR   |   |   | REG. NO.  |  |                                      |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   |   | 2a. DATE OF DEATH   |  | 2b. HOUR                             |  |
| FIRST MIDDLE LAST<br>Richard Golden  |   |   | MONTH DAY YEAR<br>November 5 1981                                   |  | 1050am                               |  |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | 7. BALTIMORE CITY OR COUNTY OF DEATH |  |
| Male   | CAU   | MONTH DAY YEAR<br>JUNE 12 1922  | 59 YRS.   |  | Anne Arundel County MD.              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                      |  |
| Baltimore, Md.   | U.S.A.  |   | Anne Arundel County MD.   |  |                                      |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |  | 12b. KIND OF BUSINESS OR INDUSTRY    |  |
| Ft. Meade, Md.   | Kimbrough Army Community Hospital   |   | Civil Service   |  | U.S. Gov't.                          |  |
| 13a. STATE   | 13b. COUNTY   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS  |                                      |  |
| Maryland   | Baltimore   | BALTIMORE   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 6241 Robin Hill Road/Baltimore, Maryland   |                                      |  |
| 14. FATHER'S NAME  |   | 15. MOTHER'S MAIDEN NAME  |   | 16. SOCIAL SECURITY NO.  |                                      |  |
| FIRST MIDDLE LAST<br>John JAY Golden   |   | FIRST MIDDLE LAST<br>Mildred Lipsitz  |   | 213-14-5839  |                                      |  |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |   | 17b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS  |                                      |  |
| Yes  |   | WW II   |   | Wife - Sarah - 6241 Robin Hill Road/Baltimore, Md.   |                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u><br><br>4100 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Probable myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) |   |   |   |  |                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |   |  |                                      |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?  |                                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|  |   |   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                      | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.   |   |   |   |  |                                      |  |
| 22b. SIGNATURE   |   | DEGREE  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                      | 22c. DATE SIGNED   |
| James D. Fitz, MAJ, MC   |   |   |   |  |                                      | 5 Nov 81   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   | 22e. ADDRESS  |   | 22f. LOCATION  |                                      |  |
|  |   | Ft. Meade, Md.  |   | ROSEDALE, MD.  |                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |   | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY   |                                      | 23d. LOCATION  |
| BURIAL   |   | 11-6-81   |   | JEWISH WAR VETERANS  |                                      | CITY OR TOWN COUNTY STATE                                      |
| 24. FUNERAL DIRECTOR   |   | 25a. DATE REC'D. BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE   |                                      |  |
| SOL LEVINSON & BROS.<br>6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)   |   | NOV 10 1981   |   | James J. Nathan  |                                      |  |

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 1, 1861.

2. The second part is a report from the Secretary of the Treasury, dated January 1, 1861.

3. The third part is a report from the Secretary of the Interior, dated January 1, 1861.

4. The fourth part is a report from the Secretary of the Navy, dated January 1, 1861.

5. The fifth part is a report from the Secretary of the War, dated January 1, 1861.

6. The sixth part is a report from the Secretary of the State, dated January 1, 1861.

7. The seventh part is a report from the Secretary of the War, dated January 1, 1861.

8. The eighth part is a report from the Secretary of the Navy, dated January 1, 1861.

9. The ninth part is a report from the Secretary of the War, dated January 1, 1861.

10. The tenth part is a report from the Secretary of the Navy, dated January 1, 1861.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  | REG. NO.   |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  |  |  |  |  |  | 81 27896   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Elizabeth Goodell</b>  |  |  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-29-81</b>                         |  | 2b. HOUR<br><b>10:30 PM</b>  |  |  |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>white</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 18 10</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.                               |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.          |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel</b> MD                  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Annapolis</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Anne Arundel General</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. CITY OR TOWN<br><b>Chester</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>RT #1 Box 340</b>                                    |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>LESLIE WAYNE BAKER</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>AMEY HERSHNER</b>  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br><b>215-12-3602</b>   |  | 17 INFORMANT<br><b>CHARLES P. GODDELL</b>  |  | ADDRESS<br><b>RT #1 Box 340 21679</b>  |  |  |  |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cirrhosis of liver</b><br><b>5712</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic Alcoholism</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1<br><b>① Hepato-renal syndrome ② Cancer of ③ Breast</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET  |  | CITY OR TOWN   |  | COUNTY STATE   |  |
| 22a. I certify that (I) [this hospital] attended the deceased from <b>11-29-81</b> 19 <b>81</b> to <b>11-29-81</b> 19 <b>81</b> that (I) (we) last saw the deceased alive on <b>11-29-81</b> 19 <b>81</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Errol A. Phillips</b>   |  |  |  | DEGREE<br><b>MD</b>  |  |  |  | 22c. DATE SIGNED<br><b>11-29-81</b>                                      |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ERROL A. Phillips</b>  |  |  |  | 22e. ADDRESS<br><b>20 Ridge by the Bay Annapolis MD</b>  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>CREMATION</b>  |  | 23b. DATE<br><b>11-30-81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR HILL CREMATORY</b>  |  | 23d. LOCATION<br>CITY OR TOWN<br><b>SUITLAND</b>                               |  | COUNTY<br><b>P.G. Co.</b>  |  | STATE<br><b>MD</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HELFENBEIN-HUBBARD FUNERAL HOME</b>   |  |  |  | ADDRESS<br><b>RT #1 Box 66B CHESTER MD.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 1 1981</b>                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                         |  |  |  |



*[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. The text appears to be organized into several paragraphs.]*

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

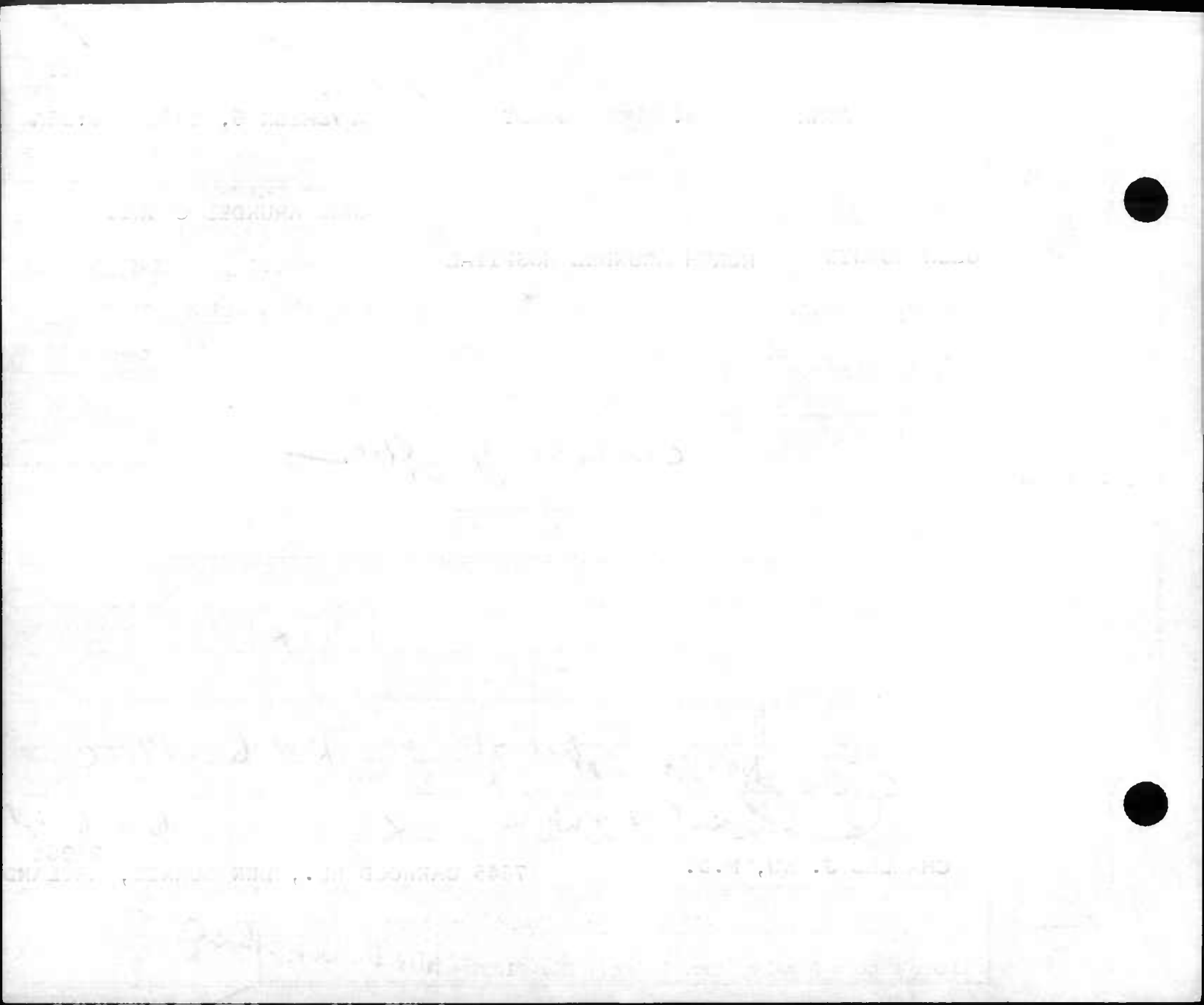
8 1 2 7 8 9 7

1. FOR  
STATE  
REGISTRAR

REG. NO.

EST

|  |  |  |  |   |                                      |  |
|--|--|--|--|---|--------------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JOHN William GOODY</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 6, 1981</b> |   | 2b. HOUR<br><b>9:55A<sub>M</sub></b> |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 12 1909</b>  |                                      |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.  |  | 7. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                      |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>  |  | 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b>                  |                                      |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Personnel</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Civil Servant</b>  |  | 13. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY</b> MD.   |                                      |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>A.A. County</b>  |  | 13c. CITY OR TOWN<br><b>Severna Park</b>  |                                      |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>5 Sullivan Drive</b>   |  | 13f. ZIP CODE<br><b>21146</b>   |                                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John W. Goody</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Maria Larson</b>   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes WWII</b>  |                                      |  |
| 16b. SOCIAL SECURITY NO.<br><b>167/10/6657</b>   |  | 17. INFORMANT<br><b>Doris L. Goody</b>   |  | 17. ADDRESS<br><b>Same as 13e.</b>  |                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary arteries</u><br><b>57/15</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |   |                                      |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                      |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS DURING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)    |  |   |                                      |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |                                      |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 21</u> 19 <u>81</u> to <u>Nov. 6</u> 19 <u>81</u> that (I) (we) last saw the deceased alive on <u>Nov. 5</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.  |  |  |  |   |                                      |  |
| 22b. SIGNATURE<br><u>Charles J. Wu</u>   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>Nov. 6, 1981</u>   |                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CHARLES J. WU, M.D.</b>  |  | 22e. ADDRESS<br><b>7845 OAKWOOD RD., GLEN BURNIE, MARYLAND 21061</b>   |  |   |                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  | 23b. DATE<br><b>11/7/1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Mount Cemetery</b>   |                                      |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Walter Brooks Bradley Inc. balto., Md. 21222</b>  |  |   |                                      |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 14 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |   |                                      |  |



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ETTA O GORE   |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>NOVEMBER 20, 1981   |  | 2b. HOUR<br>12:45 <sup>M</sup>   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Oct. 1, 1888   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>93 YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Mississippi   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ANNE ARUNDEL COUNTY MD                                  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>GLEN BURNIE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NORTH ARUNDEL HOSPITAL |  |   |  | 12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)<br>Domestic                       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>At Home   |  |
| 13a. STATE<br>Virginia   |  | 13b. COUNTY<br>Henry   |  | 13c. CITY OR TOWN<br>Fieldale   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>RFD #1  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>John O'Neal   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Unknown   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>228 09 5087  |  | 17. INFORMANT ADDRESS<br>Mrs. Thadie Mae G. Dodge Glen Burnie, Md.  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio pulmonary arrest<br>4292 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Sudden<br>years |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Peripheral vascular insufficiency  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-3-81 to 12-20-81, that (I) (we) last saw the deceased alive on 11-19-81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE DEGREE<br>JACK I. STERN, M.D., P.A.   |  |  |  |   |  | 22c. DATE SIGNED<br>11-20-81  |  | 22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JACK I. STERN, M.D., P.A.   |  |  |  | 22f. ADDRESS<br>300 HOSPITAL DRIVE, SUITE 135<br>GLEN BURNIE, MARYLAND 21061  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>11/22/1981  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Boselawn  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Martinsville, Va.                                    |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>James O. Buck   |  |  |  |   |  |   |  |  |  |
| 25a. DATE REC'D. BY REGISTRAR<br>NOV 30 1981   |  |  |  |   |  |   |  |  |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |                         |  |   |   |  |  |  |   |
|--|-------------------------|--|---|---|--|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Lloyd B. GREEN</b>  |                         |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <b>11 21 1981</b>      |   |  | 2b. HOUR <b>7 P M</b>  |  |   |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>WHITE</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>JUNE 8 1909</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>72 YRS</b>            | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>11 21 1981</b>                                   | 2d. HOUR <b>7 P M</b>  |  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW YORK</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel MD.</b>          |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>glen Burnie</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>North. Arundel Hosp</b> |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>DENTAL TECH.</b>           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>WALTER REED Hosp</b> |   |
| 13a. STATE<br><b>MARYLAND</b>  |                         |  | 13b. COUNTY<br><b>ANNE ARUNDEL</b>                          | 13c. CITY OR TOWN<br><b>LAUREL</b>  | 13d. INSIDE CITY LIMITS<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>3248 SUDLESVILLE SO.</b>                       |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ARTHUR P. GREEN</b>   |                         |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>GERTRUDE FURMAN</b>   |  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>YES.</b>   |                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW II</b>  |   | 17. INFORMANT<br><b>RUTH G. GREEN</b>   |  | ADDRESS<br><b>3248 SUDLESVILLE SO. LAUREL MD. 20707</b>                  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Artery Disease</b><br>4149<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Instant</b>                          |                         |  |   |   |  |  |  |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                         |  |   |   |  |  |  |   |
| 19a. DATE OF OPERATION   |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                  |  |  |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                         |  |   |   |  |  |  |   |
| ACTUAL SIGNATURE<br><b>E. Linhardt</b>   |                         |  | TITLE (SPECIFY)<br><b>Deputy</b>                            |   |  | DATE SIGNED<br><b>11.21.81.</b>  |  |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>E. Linhardt</b>   |                         |  | ADDRESS<br><b>Annapolis - MD.</b>                           |   |  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |                         | 23b. DATE<br><b>11/27/81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MD. NATAL MEM. PARK</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>LAUREL P.G. Co. MD.</b> |  |   |
| 24. FUNERAL DIRECTOR<br><b>FRANK LAUREL FUNERAL HOME INC.</b>  |                         |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 27 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                         |  |   |
| 2601 SANDY SPRING RD. LAUREL MD. 20707   |                         |  |   |   |  |  |  |   |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

81 27900

|  |  |   |  |
|--|--|---|--|
| FOR<br>1. STATE<br>REGISTRAR   |  | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | 2a. DATE OF DEATH   |  |
| FIRST MIDDLE LAST<br>George J. Grail   |  | MONTH DAY YEAR<br>Nov. 28, 1981   |  |
| 2. SEX   |  | 3. DATE OF BIRTH  |  |
| Male   |  | MONTH DAY YEAR<br>Aug. 9, 1910  |  |
| 4. RACE  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |
| White  |  | 71 YRS.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |
| Maryland   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Brooklyn, Maryland A.A.M.D.   |  |
| 10. CITY OR TOWN OF DEATH<br>Brooklyn  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>413 Audrey Ave. Brooklyn, Md.                  |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Maryland   |  | 13b. KIND OF BUSINESS OR INDUSTRY<br>Maintenance Chemical Co.   |  |
| 13c. COUNTY<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 13e. STREET ADDRESS<br>1 W. Conway St. Balto. Md.  |  | 14. FATHER'S NAME<br>John   |  |
| 15. MOTHER'S MAIDEN NAME<br>Mary   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) No   |  |
| 16b. SOCIAL SECURITY NO.<br>218-07-2970  |  | 17. INFORMANT<br>Angela Johnston, 413 Audrey Ave. Balto. Md.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>2500<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ASCVD w/ Atherosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Dilated Mitral type I</u>  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |  |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)   |  | 21d. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21e. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 21f. DATE SIGNED<br>11/30/81  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/10/81</u> 19 <u>81</u> to <u>Nov 23 15</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>Nov 23 181</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br>Charles E. Battinghouse   |  |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br>C.N. Battinghouse Sr.   |  | 22d. ADDRESS<br>403 E. Battinghouse 21225   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>Dec. 1, 1981   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>McCutty Funeral Home, 130 E. Fort Ave. Balto. Md.  |  | 25a. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>DEC 3 1981 Thomas Jan Thelen  |  |

1891-1892

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |   |   |  | 81 27901   |  |
|--|---|---|--|--|--|
| 1. FOR STATE REGISTRAR   |   |   |  | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Ann M. Grimm  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Nov. 16, 1981   |  | 2b. HOUR<br>M  |
| 3. SEX<br>Female   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 13, 1923   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br>58  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel Co. MD.   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Riviera Bch.  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>228 Carroll Rd., Riviera Bch |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Nurse  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Medical                     |  |
| 13a. STATE<br>Md.  | 13b. COUNTY<br>Worcester  | 13c. CITY OR TOWN<br>Ocean City   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET ADDRESS<br>148 S. Ocean Dr.                          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James J. Gannon  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Delta R. Keaveney  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>yes  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>W.W.II   | 17. INFORMANT<br>ADDRESS<br>Anthony Grimm 510 Druid Hill Ave.  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio respiratory Failure<br>3960<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) Rheumatic heart disease<br>(c) aortic & mitral prosthesis<br>DUE TO, OR AS A CONSEQUENCE OF<br>1961<br>10 yrs<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |   |   |  |  | 21.201<br>INTERVAL<br>BETWEEN ONSET AND DEATH<br>sudden  |
| 19a. DATE OF OPERATION   |   |   |  |  |  |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |
| 22a. I certify that (I) <del>the hospital</del> attended the deceased from 19 61, to 11/16, 19 81, that (I) <del>we</del> lost saw the deceased alive on 5/17, 19 81, and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>we</del> <del>did</del> (did not) view the body after death.  |   |   |  |  |  |
| 22b. SIGNATURE<br>John R Davis, M.D.   |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>11/17/81   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John R Davis, M.D.  |   |   | 22e. ADDRESS<br>401 Medical Arts Bldg  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   | 23b. DATE<br>11/19/81   | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.     |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Gonce Funeral Home   |   | Balto. Md. 21225<br>4001 Ritchie Hgwy.  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 17 1981                     | 25b. REGISTRAR'S SIGNATURE<br>Thane J. [Signature]   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 1 2 7 9 0 2  |  |
|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | CERTIFICATE OF DEATH                                     |  |
| 1. DECEASED NAME   |  |  |  | 2a. DATE OF DEATH  |  |
| FIRST MIDDLE LAST  |  |  |  | MONTH DAY YEAR   |  |
| EDWARD ARTIE GRINNAN   |  |  |  | 11-8-81  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  |
| Male   |  | White  |  | MONTH DAY YEAR   |  |
|  |  |  |  | 10 27 14   |  |
| 7a. BIRTHPLACE   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 6. AGE   |  |
| Md.  |  | U.S.A.   |  | 67 YRS   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                     |  |
| GLEN BURNIE  |  | NORTH ARUNDEL HOSPITAL   |  | ANNE ARUNDEL COUNTY MD.                                  |  |
| 12a. USUAL OCCUPATION  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| Engineer   |  | Steel  |  |  |  |
| 13a. STATE   |  | 13b. CITY OR TOWN  |  | 13c. STREET ADDRESS                                      |  |
| Md.  |  | Glen Burnie  |  | 409 Secluded Post Circle                                 |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |
| Areat C. Grinnan   |  | Bertha Brier   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS                                    |  |
| Yes  |  | 218-03-3901  |  | Evelyn Hinshaw Pasadena, Md.                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |
| IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u>   |  |  |  |  |  |
| 1579   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |
| (b) <u>TERMINAL CARCINOMA OF PANCREAS</u>  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |
| (c) <u>METASTASIS</u>  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:  |  |  |  |  |  |
| <u>ASCV, ATRIAL FIBRILLATION, DIABETES MELLITUS, ASCITIS</u>   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 19c. AUTOPSY?  |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING   |  | 20b. TIME OF INJURY  |  | 20c. HOW INJURY OCCURRED                                 |  |
| <input type="checkbox"/> CAUSE OF DEATH  |  | HOUR A.M. MONTH DAY YEAR   |  | (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)    |  |
| (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | P.M. 19  |  |  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | STREET CITY OR TOWN COUNTY STATE                         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-28-81</u> , 19 <u>81</u> , to <u>11-8-</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>11-7-</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| <u>M. K. Khodabandelou M.D.</u>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 11/8/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |
| MOHAMMAD KHODABANDELOU, M.D.   |  | 1101 PATAPSCO AVENUE<br>BALTIMORE, MARYLAND 21225  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY                       |  |
| Removal  |  | 11/8/81  |  |  |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                               |  |
| NAME ADDRESS   |  | NOV 13 1981  |  | <u>[Signature]</u>                                       |  |
| Anatomy Board  |  | Balto., Md.  |  |  |  |

BP

2000

1983/11

54, 2145

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

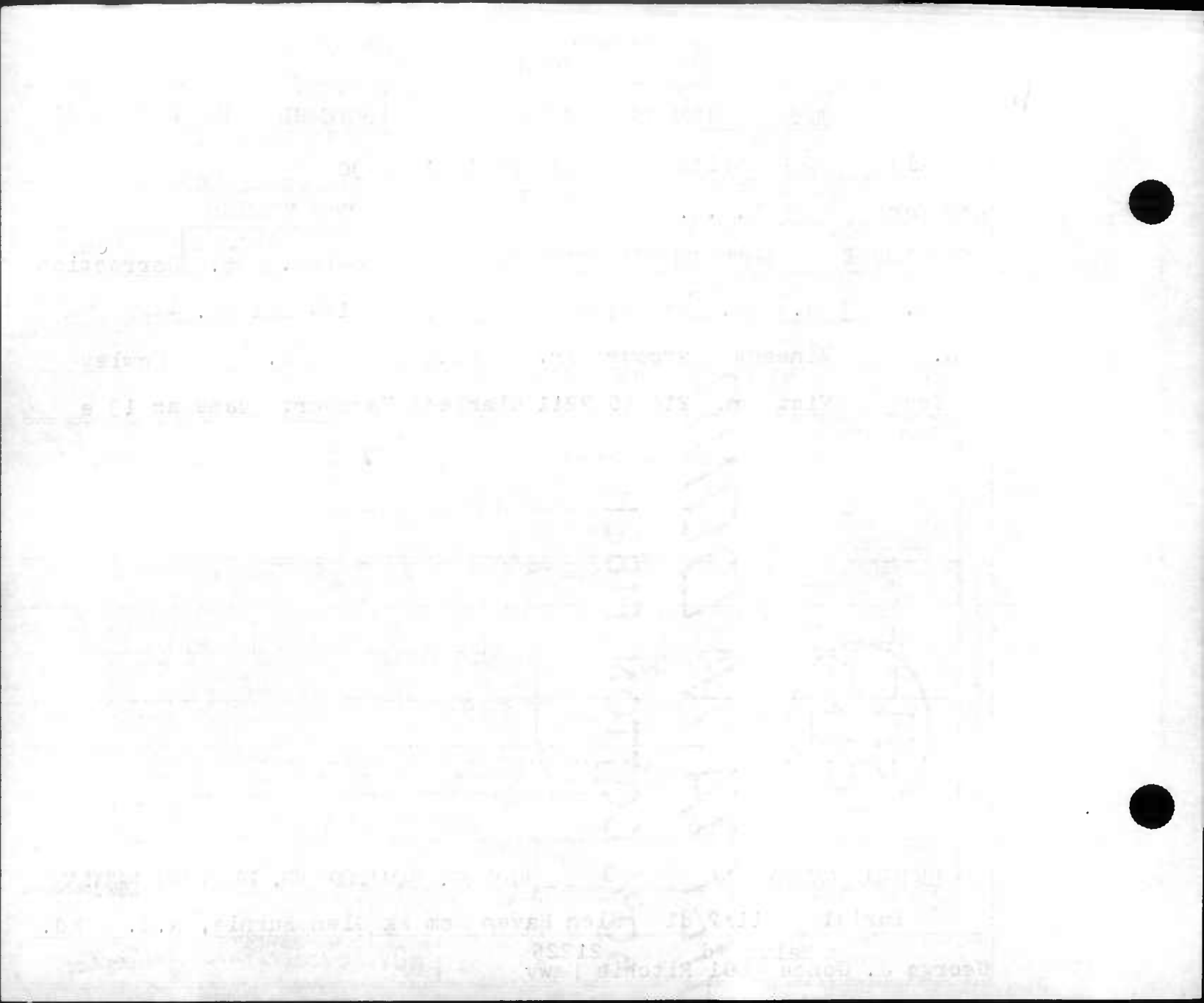
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

81 27903

REG. NO.

|  |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |                        |  |
|--|--|---|--|---|--|---|--|--|--|--|--|--|--|--|--|------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FOR<br>STATE<br>REGISTRAR   |  | FIRST<br>JOHN   |  | MIDDLE<br>FRANCIS   |  | LAST<br>HARCOURT  |  | 2a. DATE OF DEATH<br>MONTH<br>NOVEMBER   |  |  |  | DAY<br>03  |  | YEAR<br>1981   |  | 2b. HOUR<br>22 35<br>M |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH<br>Jan  |  | DAY<br>27   |  | YEAR<br>1951   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>30<br>YRS.          |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS  |  | IF UNDER 24 HRS<br>HOURS<br>MIN.                     |  |                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ANNE ARUNDEL MD.  |  |  |  |  |  |  |  |  |  |                        |  |
| 10. CITY OR TOWN OF DEATH<br>GLEN BURNIE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NORTH ARUNDEL HOSPITAL |  |   |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Admins. Sgt. |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>House of Correction   |  |  |  |                        |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY<br>A.A Co.  |  | 13c. CITY OR TOWN<br>Pasadena   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>8174 Lea Rd.  |  |  |  |  |  |  |  |                        |  |
| 14. FATHER'S NAME<br>FIRST<br>A.   |  |   |  | MIDDLE<br>Vincent   |  | LAST<br>Harcourt Jr.  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST<br>Rita  |  |  |  | MIDDLE<br>J.   |  | LAST<br>Howley                                       |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>Viet Nam   |  | 216 60 7211   |  | 17. INFORMANT<br>ADDRESS<br>Charlene Harcourt same as 13 e                                      |  |  |  |  |  |  |  |  |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrhythmia</u><br>4279<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>not known</u><br>(c) <u>not known</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>minutes</u> |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |                        |  |
| 19a. DATE OF OPERATION<br><u>None</u>  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>        |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)   |  |  |  |  |  |  |  |                        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                |  |  |  |  |  |  |  |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept -</u> 19 <u>81</u> , to <u>current</u> 19 <u>81</u> , that (I) <u>we</u> lost<br>saw the deceased alive on <u>approx Sept.</u> 19 <u>81</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated<br>above. (I) <u>we</u> (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |  |  |  |  |  |  |                        |  |
| 22b. SIGNATURE<br><u>m/gunlym</u>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><u>11/04/81</u>  |  |  |  |  |  |  |  |                        |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MICHAEL GARAHY MD   |  |   |  | 22e. ADDRESS<br>8206 FT. SMALLWOOD RD. BALTIMORE MARYLAND   |  |   |  |  |  |  |  |  |  |  |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |   |  | 23b. DATE<br>11/7/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem Pk   |  |  |  | 23d. LOCATION<br>CITY OR TOWN<br>Glen Burnie, A.A. MD. |  |  |  |  |  |                        |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>George J. Gonce  |  |   |  | Balto Md 21225  |  | ADDRESS<br>4001 Ritchie Hgwy  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 9 1981            |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Marie J. Gunter</u> |  |                        |  |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

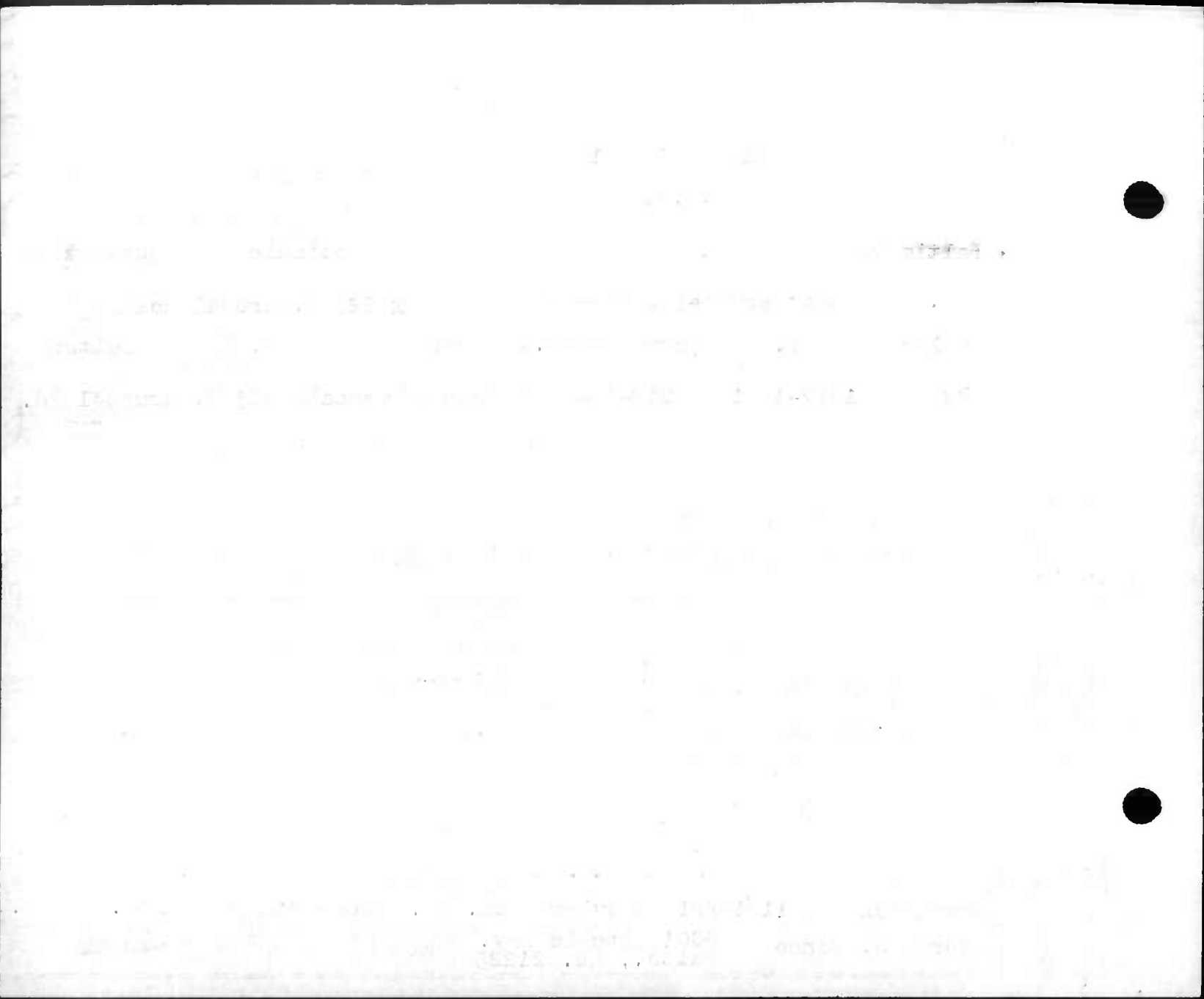
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DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

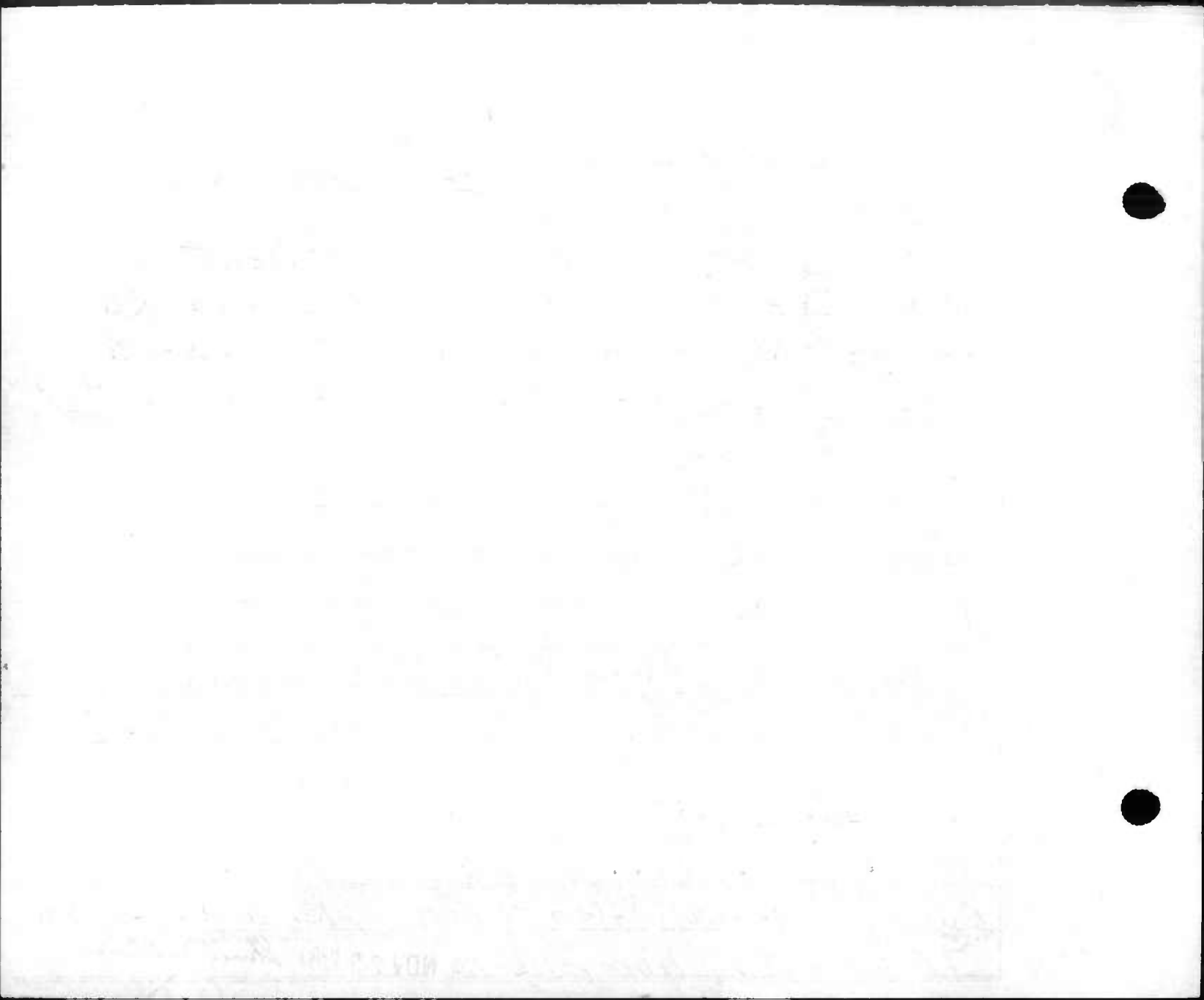
|  |  |         |  |  |  |   |  |   |  |   |  |   |  |  |  |  |  |  |  |
|--|--|---------|--|--|--|---|--|---|--|---|--|---|--|--|--|--|--|--|--|
| FOR<br>1- STATE REGISTRAR  |  |         |  |  |  |   |  |   |  | 27904   |  |   |  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |         |  |  |  |   |  |   |  | 2a. DATE KNOWN OF DEATH                                   |  |   |  |  |  |  |  |  |  |
| FIRST MIDDLE LAST<br>Douglas L Harrison, Jr  |  |         |  |  |  |   |  |   |  | X MONTH DAY YEAR 2b. HOUR<br>OF ESTI. MATED 11 13 19 81 M |  |   |  |  |  |  |  |  |  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS. |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | 7c. DATE PRONOUNCED DEAD                                  |  | MONTH DAY YEAR  |  | 2d. HOUR                                     |  |  |  |  |  |
| male   |  | white   |  | 11 3 50  |  | 31                                      |  |   |  | 11 13 19 81   |  |   |  | 8:46P  |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |         |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  |  |  |  |  |
| Md   |  |         |  | U.S.A.   |  |   |  |   |  |   |  | Anne Arundel County MD  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |  |  |
| Baltimore  |  |         |  | 225 W. Arundel Road  |  |   |  | Mechanic  |  |   |  | Automotive  |  |  |  |  |  |  |  |
| 13a. STATE   |  |         |  |  |  |   |  |   |  | 13b. COUNTY   |  |   |  |  |  |  |  |  |  |
| Md.  |  |         |  |  |  |   |  |   |  | Anne Arundel  |  |   |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |         |  |  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST             |  |   |  |  |  |  |  |  |  |
| Douglas L. Harrison Sr..   |  |         |  |  |  |   |  |   |  | Eva C. Bolton   |  |   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |  |         |  | 16b. SOCIAL SECURITY NO.   |  |   |  | 17. INFORMANT   |  |   |  | ADDRESS   |  |  |  |  |  |  |  |
| yes  |  |         |  | 1977-1981  |  |   |  | 217-52-3085   |  |   |  | Sharon Overcash 225 W. Arundel Rd.  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) GUNSHOT WOUND OF HEAD Weapon: Handgun<br>9550<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |  |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |         |  |  |  |   |  |   |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>? P.M. 11/13 19 81                                      |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>self inflicted wound   |  |   |  |   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>home  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>225 W. Arundel Road, AA Co. MD   |  |   |  |   |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural Causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |         |  |  |  |   |  |   |  |   |  |   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br>Hormez R. Guard  |  |         |  | TITLE (SPECIFY)<br>M.D. Assistant  |  |   |  | MEDICAL EXAMINER  |  |   |  | DATE SIGNED 11/14/81  |  |  |  |  |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |  |         |  | ADDRESS  |  |   |  |   |  |   |  |   |  |  |  |  |  |  |  |
| Hormez R. Guard, M.D.  |  |         |  | 111 Penn Street, Balto., MD 21201  |  |   |  |   |  |   |  |   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |         |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY      |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                |  |   |  |  |  |  |  |  |  |
| Cremation  |  |         |  | 11/16/81   |  | Westview Mem. Pk.                       |  |   |  | Catonsville Balto. Md.                                    |  |   |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |         |  | ADDRESS  |  |   |  | 25a. DATE REC'D BY REGISTRAR  |  |   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |  |  |
| George J. Gonce  |  |         |  | 4001 Ritchie Hwy.<br>Balto., Md. 21225   |  |   |  | NOV 17 1981   |  |   |  | [Signature]   |  |  |  |  |  |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH-17  
(VR A15 ME (5))  
15M 2/80

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                  |  |  |  |  |  |  |  | REG. NO. 27905   |  |
|--|--|------------------|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |                  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Debra Lynn Harwood  |  |                  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH<br>XX MONTH DAY YEAR<br>11 18 1981   |  |
| 3. SEX<br>female   |  | 4. RACE<br>white |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10-15-64   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>17 YRS.       |  | IF UNDER 1 YR. MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Georgia   |  |                  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>11 18 1981   |  |
| 10. CITY OR TOWN OF DEATH<br>Glen Burnie   |  |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>North Arundel Hospital |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Student   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Md   |  |                  |  |  |  |  |  |  |  | 13b. COUNTY<br>AA  |  |
| 13c. CITY OR TOWN<br>Serern  |  |                  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 13e. STREET ADDRESS<br>1353 Ava Rd.  |  |                  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George M. Harwood  |  |                  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary T. Harwood   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |                  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>219-92-5924   |  |  |  | 17. INFORMANT ADDRESS<br>Geo. M. Harwood #13   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple injuries<br>8120<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF |  |                  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>8:43P. 11/18/81   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>driver in an auto/auto collision  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>roadway   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Rt 175 and Baldwin, Odenton, AA Co., MD   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                                    |  |                  |  |  |  |  |  |  |  | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |
| ACTUAL SIGNATURE<br>H. S. Gaurd  |  |                  |  | TITLE (SPECIFY)<br>Assistant   |  |  |  | DATE SIGNED<br>11/19/81  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Hormez R. Gaurd, M.D.   |  |                  |  | ADDRESS<br>111 Penn Street, Balto. MD 21201  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |                  |  | 23b. DATE<br>11-21-81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haren |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Glen Burnie AA Md.   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>TA Hardesty  |  |                  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 23 1981     |  |  |  |  |  |
| ADDRESS<br>Annapolis Md.   |  |                  |  |  |  | REGISTRAR'S SIGNATURE<br>Anne Jan Norton         |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed by the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |   |  |  |  |
|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>HENRY CLIFTON HAWKINS  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>Nov. 22 1981   |  | 2b. HOUR<br>8:37 AM  |
| 3. SEX<br>MALE  | 4. RACE<br>BLACK  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Mar 15 1934   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>47 YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>md   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>A.A. MD  |  |  |
| 10. CITY OR TOWN OF DEATH<br>ANNAPOLIS  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>A.A. GENERAL |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Auto Repair  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>md  | 13b. COUNTY<br>A.A.   | 13c. CITY OR TOWN<br>ANNAPOLIS  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 13e. STREET ADDRESS<br>1503-D West St<br>1215 Madison St Apt B-2               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Wm HAWKINS, Sr  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret Wm JOHNSON  |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO                                      |  |  |
| 16b. SOCIAL SECURITY NO.<br>215-30-2980   |   | 17. INFORMANT<br>Shirley HAWKINS 1215 Madison St Apt B-2  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) RESPIRATORY FAILURE<br>1629<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) PNEUMONIA<br>(c) METASTATIC CARCINOMA OF LUNG  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Acute<br>1 MONTH<br>MONTHS   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 11/2 19 81, to 11/22 19 81, that (1) (we) lost saw the deceased alive on 11/21 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. |   |   |  |  |  |
| 22b. SIGNATURE<br>David S. Krimins  |   | DEGREE<br>MD  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>11/28/81   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DAVID S. KRIMINS MD  |   | 22e. ADDRESS<br>25 Shaw St ANNAPOLIS, MD  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>Nov 25, 1981   | 23c. NAME OF CEMETERY OR CREMATORY<br>MT. CALVARY   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arnold A.A. MD   | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>C.F. Hicks 1922 Forest Drive ANNAPOLIS |  |
| 24b. DATE REC'D. BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE<br>Nov 30 1981   |  |  |  |



DATE: 10/10/50  
BY: [illegible]  
FOR: [illegible]

1000 D. B. 10/10/50

1000 D. B. 10/10/50  
1000 D. B. 10/10/50  
1000 D. B. 10/10/50

1000 D. B. 10/10/50  
1000 D. B. 10/10/50  
1000 D. B. 10/10/50

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

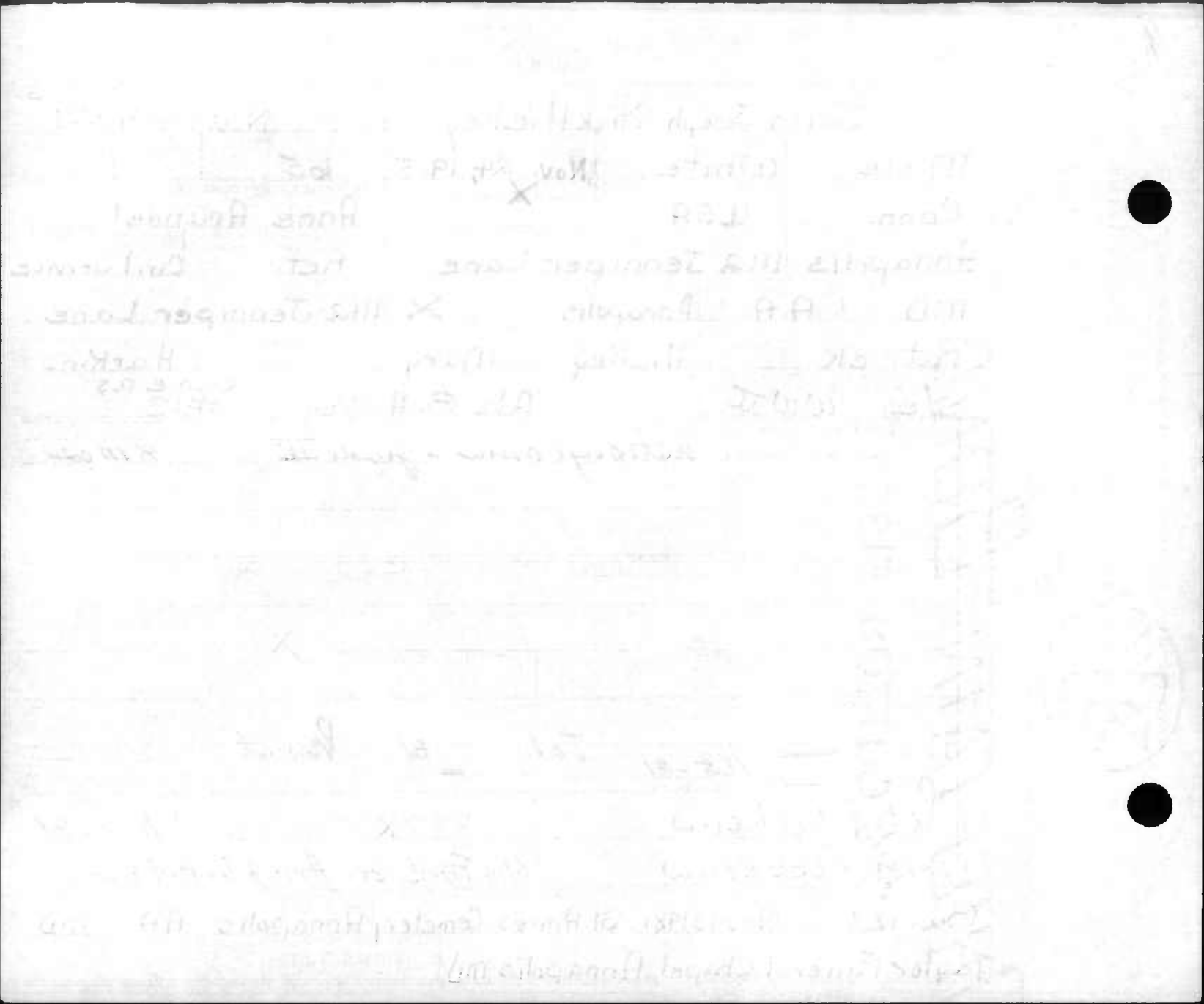
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 1 2 7 9 0 7   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>John Joseph Patrick Hickey</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Nov. 10 1981</b>   |  |   |  |
| 3. SEX<br><b>Male</b>   |  |  |  | 2b. HOUR<br><b>8:23 P</b>   |  |   |  |
| 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Nov. 24, 1915</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Conn.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Annapolis</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1112 Jennifer Lane</b>  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret.</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Civil Service</b>   |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>A.A.</b>   |  | 13c. CITY OR TOWN<br><b>Annapolis</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Patrick Hickey</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary Harkins</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes WW II</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>Ada B. Hickey</b>  |  |
| 17. INFORMANT<br><b>Same as #13</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Astrocytoma - grade IV</b><br>1919 DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>8 mos</b>  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>Feb 81</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>Feb 81</b> to <b>Present</b> , that (I) (we) saw the deceased alive on <b>11-5-81</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Peter F. Verhouw</b>   |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>11-11-81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PETER F. VERKOUW</b>  |  | 22e. ADDRESS<br><b>1419 Frost Dr. Annapolis Md 21403</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Nov. 13, 1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Anne's Cemetery</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Annapolis AA MD</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Taylor Funeral Chapel, Annapolis, Md</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 13 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>James Van Nether</b>   |  |   |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 9 0 8

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST: Kelly, MIDDLE: Ann, LAST: Hicks   |   |   | 2a. DATE OF DEATH<br>MONTH: 11, DAY: 28, YEAR: 81   |  | 2b. HOUR<br>9:00 P.M.  |
| 3. SEX<br>Female  | 4. RACE<br>Cauc   | 5. DATE OF BIRTH<br>MONTH: 4, DAY: 4, YEAR: 67  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>14 YRS.   | IF UNDER 1 YEAR<br>MONTHS: , DAYS: , HOURS: , MIN: .   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel County MD.                      |  |
| 10. CITY OR TOWN OF DEATH<br>Edgewater  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>4176 Carroll Drive |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Student                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-   |
| 13a. STATE<br>MD  | 13b. COUNTY<br>A.A.   | 13c. CITY OR TOWN<br>Edgewater  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br>4176 Carroll Drive  |  |
| 14. FATHER'S NAME<br>FIRST: Winfield, MIDDLE: A., LAST: Hicks   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST: Patricia, MIDDLE: , LAST: Lemerick   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) NO   |   | 16b. SOCIAL SECURITY NO.<br>-   |   | 17. INFORMANT<br>Winfield A. Hicks   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a). Lymphoma<br>2028<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b).<br>(c).<br>DUE TO, OR AS A CONSEQUENCE OF                       |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |   |  |  |
| 22b. SIGNATURE<br>Stanley R. Weiner, M.D.   |   |   |   | 22c. DATE SIGNED<br>11-29-81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Stanley R. Weiner, M.D.  |   |   |   | 22e. ADDRESS<br>1517 R. Ichie Hwy Arnold, Md.  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |   | 23b. DATE<br>Nov-30-1981  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Ft Lincoln                                     |  |
| 23d. LOCATION<br>CITY OR TOWN<br>Brentwood P.G.   |   | 23e. COUNTY<br>MD   |   | 23f. STATE   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Taylor Funeral Chapel, Annapolis, MD  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 1 1981  |  |
| 25b. REGISTRAR'S SIGNATURE<br>Rene J. [Signature]   |   |   |   |  |  |

MEDICAL CERTIFICATION

2  
9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

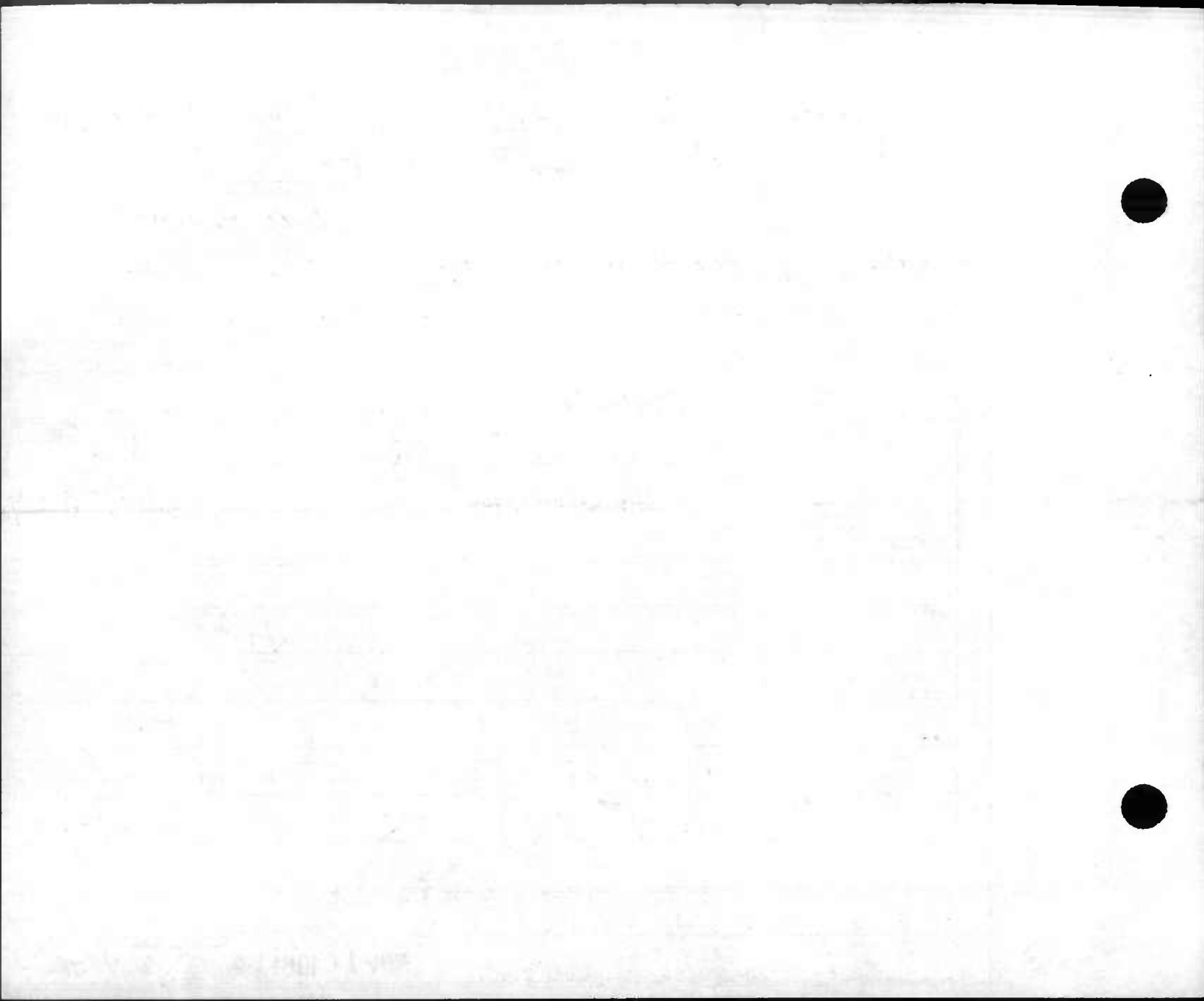
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 9 0 9

#5, Film G561 11/16/81 kam  
1 - STATE REGISTRAR

REG. NO.

|   |  |   |  |  |  |   |  |  |    |  |
|---|--|---|--|--|--|---|--|--|----|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Beatrice N. Hill</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>Nov. 9 1981</b>                 |  |  | 2b. HOUR<br><b>12M</b>  |  |  |    |  |
| 3 SEX<br><b>F</b>   |  | 4 RACE<br><b>W</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Jan 5 1901</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |    |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Bridgeport, Conn</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel</b>                                      |  |  | MD |  |
| 10 CITY OR TOWN OF DEATH<br><b>Annapolis</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Anne Arundel Gen. Hosp.</b> |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Household</b>  |    |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Anne Arundel</b>  |  | 13c. CITY OR TOWN<br><b>Crofton</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1588 Bandury Ct. 21114</b>   |    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Cecil Nellleton</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Virginia Beaver</b>  |  |   |  |  |    |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>109-10-6841</b>  |  | 17 INFORMANT<br><b>Virginia H. Donohue</b>   |  |   | ADDRESS<br><b>Same as # 13</b>                                     |  |    |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Infarction</b><br>4349<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Acute</b><br><b>Long-standing</b> |  |   |  |  |  |   |  |  |    |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>11</b>  |  |   |  |  |  |   |  |  |    |  |
| 19a. DATE OF OPERATION<br><b>29</b>   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>      |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |  |    |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |    |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>11/9</b> , 19 <b>81</b> , to <b>11/10</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) we (did) (did not) view the body after death.  |  |   |  |  |  |   |  |  |    |  |
| 22b. SIGNATURE<br><b>Dr. W. S. Hill</b>   |  |   |  |  |  | 22c. DATE SIGNED<br><b>11/10/81</b>   |  |  |    |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. W. S. Hill</b>  |  |   |  |  |  | 22e. ADDRESS<br><b>Westview Cemetery</b>  |  |  |    |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |  |   | 23b. DATE<br><b>11-10-81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Cemetery</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b> |  |    |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>T.A. Hardesty Annapolis, Maryland 21401</b>  |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 10 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Frances Jan Warren</b>  |    |  |



Items #15a-22a Film G561 11/23/81r STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

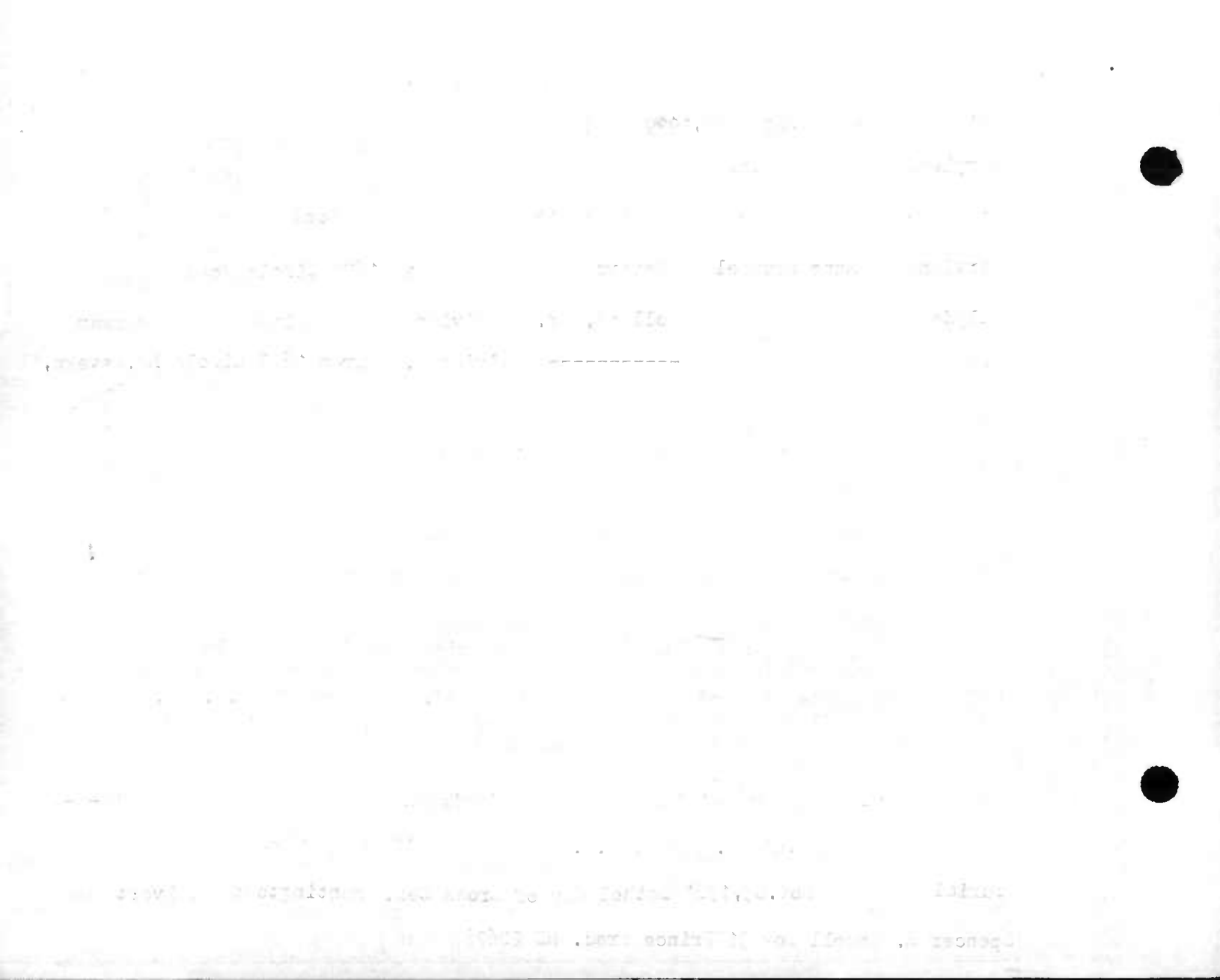
|  |                            |  |   |   |
|--|----------------------------|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Clyde   |                            | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br>11 5 1981   |   | 2b. HOUR<br>M<br>7:31 P.M.  |
| 3. SEX<br>Male   | 4. RACE<br>Black           | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 27, 1979   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>2 YRS.   | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |                            | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH<br>Glen Burnie   |                            | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>North Arundel Hospital |   | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>None  |
| 13a. STATE<br>Maryland   |                            | 13b. COUNTY<br>Anne Arundel  | 13c. CITY OR TOWN<br>Severn   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Clyde  |                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Vivian Linda Parran   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |                            | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-----   |   | 17. INFORMANT<br>ADDRESS<br>Vivian L. Parran 1677 Circle Rd. Severn, MD   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Blunt injury to abdomen with liver laceration and hemoperitoneum<br>(b) laceration and hemoperitoneum<br>(c) -----<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |                            |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |                            |  |   |   |
| 19a. DATE OF OPERATION   |                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                            | 21b. TIME OF INJURY<br>HOUR:MIN. MONTH DAY YEAR<br>4:30 P.M. 11/5/ 81  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>pedestrian struck by bicycle |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK  |                            | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>road  | 21f. LOCATION<br>STREET CITY OR TOWN A.A. Co. Md. STATE<br>Circle Rd. Severn                                  |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                            |  |   |   |
| ACTUAL SIGNATURE<br>Virginia L. Dolan  |                            | TITLE (SPECIFY)<br>M.D. Assistant  |   | DATE SIGNED<br>11-6-81  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Virginia L. Dolan, M.D.  |                            | ADDRESS<br>111 Penn Street   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   | 23b. DATE<br>Nov. 05, 1981 | 23c. NAME OF CEMETERY OR CREMATORY<br>Bethel Way of Cross Cem.   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Huntingtown Calvert MD  |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Spencer E. Sewell Box 31 Prince Fred. MD 20678   |                            | 25a. DATE REC'D. BY REGISTRAR<br>NOV 12 1981   | 25b. REGISTRAR'S SIGNATURE<br>James J. Nathan   |   |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR TO FUNERAL DIRECTOR; PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (1))  
15M/2/80



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, payment should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 2.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  | 8 1 2 7 9 1 1 |  |
|--|--|---|--|---|--|---|--|--|--|---------------|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.  |  |   |  |   |  |  |  |               |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Athalia Berryman Holmes</i>   |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>11 21 81</i>  |  | 2b. HOUR<br><i>5:30 AM</i>   |  |               |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>Caucasian</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>08 10 00</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>81</i> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |               |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN)<br>COUNTRY<br><i>PA</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Anne Arundel</i> MD.                                 |  |  |  |               |  |
| 10. CITY OR TOWN OF DEATH<br><i>Annapolis</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Anne Arundel Gen'l Hosp</i> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Clerk</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>State of Md</i>   |  |  |  |               |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><i>MD</i>   |  | 13b. COUNTY<br><i>Carroll</i>   |  | 13c. CITY OR TOWN<br><i>Syksville</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>Fairhaven</i>  |  |               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>William Irving Berryman</i>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Mary Todd</i>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <i>No</i>  |  |   |  |  |  |               |  |
| 16b. SOCIAL SECURITY NO.<br><i>214-26-3133A</i>  |  | 17. INFORMANT<br><i>Capt. William B. Morrow</i><br>ADDRESS<br><i>401 ARUNDEL PLACE, P.O. Box 889, Annapolis, MD 21406</i>                   |  |   |  |   |  |  |  |               |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>CVA - left hemiplegia</i><br>4360 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. <i>generalized arteriosclerosis</i><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>10 days</i><br><i>6 yrs</i> |  |   |  |   |  |   |  |  |  |               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>0</i>  |  |   |  |   |  |   |  |  |  |               |  |
| 19a. DATE OF OPERATION<br><i>11-11-81</i>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Bunion, rt foot</i>  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1975</i> to <i>11-21-81</i> , that (I) (we) lost<br>saw the deceased alive on <i>11-20-81</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |               |  |
| 22b. SIGNATURE<br><i>Frank Shipley, M.D.</i>   |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |   |  | 22c. DATE SIGNED<br><i>11-21-81</i>  |  |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>F.M. SHIPLEY</i>   |  | ADDRESS<br><i>Annapolis, Md</i>   |  |   |  |   |  |  |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Cremation</i>   |  | 23b. DATE<br><i>Nov. 21, 1981</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Ft. Lincoln</i>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Brentwood P.G. MD</i>                          |  | 25a. DATE REC'D BY REGISTRAR<br><i>NOV 24 1981</i>   |  |               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Taylor Funeral Chapel, Annapolis, MD</i>  |  | ADDRESS   |  | 25b. REGISTRAR'S SIGNATURE<br><i>James J. [Signature]</i>   |  |   |  |  |  |               |  |

MEDICAL CERTIFICATION

4

ac  
31112

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

DHMH - 16 50M 1(B)  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 9 1 2

|  |  |  |   |  |  |
|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |   | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 2a. DATE OF DEATH  |   | 2b. HOUR   |  |
| FIRST MIDDLE LAST  |  | MONTH DAY YEAR   |   | HOURS MIN.   |  |
| William B. HORTON  |  | 11 22 81   |   | 9:25 P.M.  |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | 7. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| male   | white  | MONTH DAY YEAR   | 85 YRS.   | BALTIMORE CITY OR COUNTY OF DEATH  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. ANNE ARUNDEL CO MD   |  |  |
| North Carolina   | USA  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |
| Annapolis  | ANNE ARUNDEL General Hospital  | Retired Self Employed - Jeweler  |   |  |  |
| 13a. STATE   | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS  |  |
| MD   | AA   | Riva   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 3601 Cedar Hill Rd   |  |
| 14. FATHER'S NAME  | 15. MOTHER'S MAIDEN NAME   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |   |  |  |
| John B. HORTON   | Susie BAIRD HORTON   | 16b. SOCIAL SECURITY NO. 578-466948  |   |  |  |
| 17. INFORMANT  |  | 17a. ADDRESS   |   |  |  |
| Sue Scheig   |  | 716 Hillmeade Rd. Glann Dale, Md.  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Prostatic Cancer, 1850   |  |  |   |  | 4 yrs.                                       |
| DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic  |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?  |  |
|  |  |  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
|  |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |
|  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 19 76, to Nov 22 81, that (I) (we) lost saw the deceased alive on 12 Nov 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |
| 22b. SIGNATURE   |  |  |   | 22c. DATE SIGNED   |  |
| William H. Choate, MD  |  |  |   | 23 Nov 81.   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |   | 22e. ADDRESS   |  |
| William H. Choate  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| BURIAL   |  | 11-27-81   |   | DAVIDSONVILLE United Methodist Ch.   |  |
| 24. FUNERAL DIRECTOR   |  | 24a. NAME  |   | 24b. ADDRESS   |  |
| Beall Funeral Home   |  | 16,000 Annapolis Rd. Bowie, Md.  |   |  |  |
| 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR   |   |  |  |
| NOV 27 1981  |  | James J. [Signature]   |   |  |  |

BP

25

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "received" and "amount" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

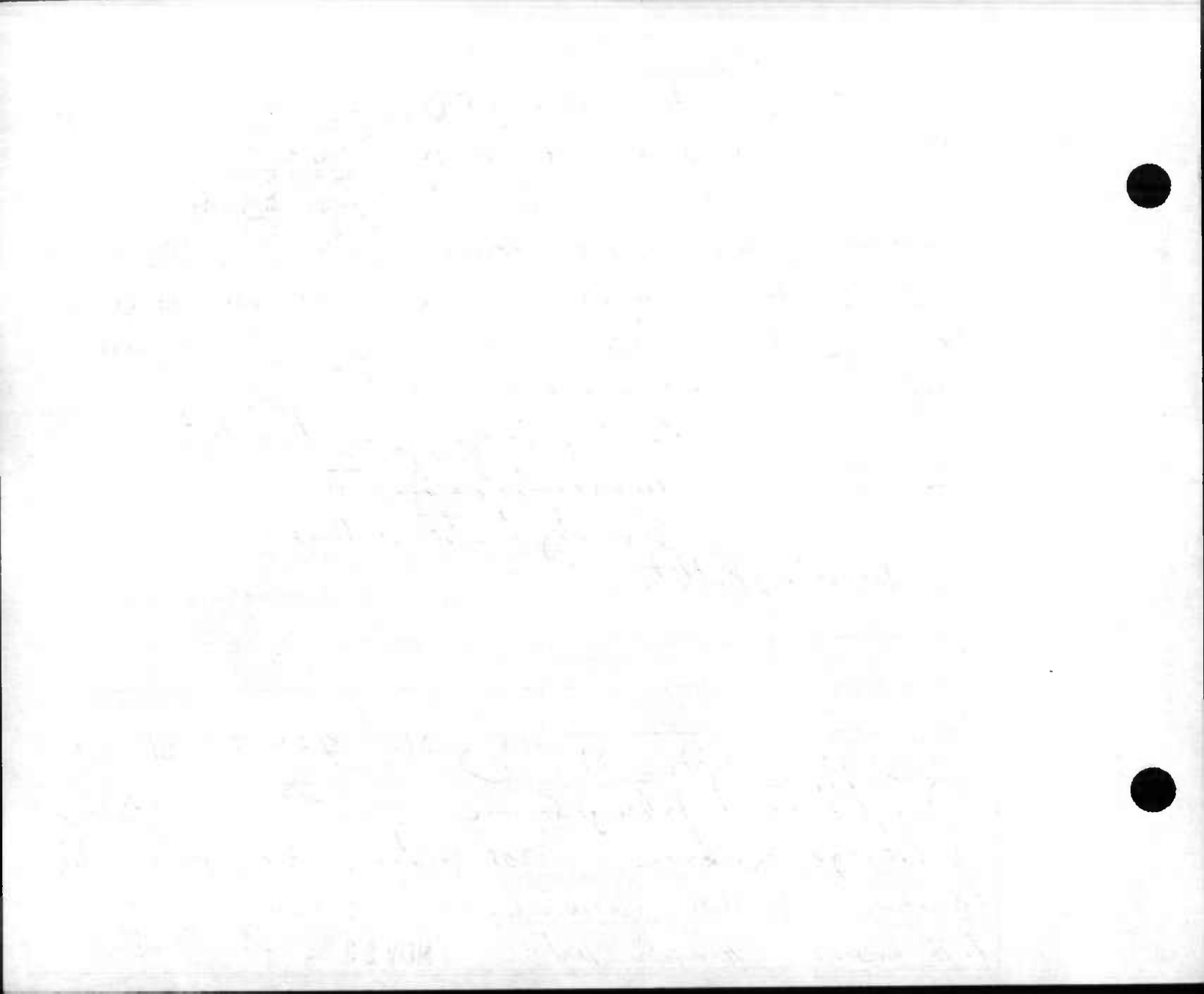
8 1 2 7 9 1 3

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>JACK C. HOSFORD</b>  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11 22 81</b>                               |   | 2b. HOUR<br><b>3:00 P</b>  |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>Caucasian</b>   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>4 27 18</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS                                  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN.                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>ANNAPOLIS</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL</b> MD.                   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>ANNAPOLIS</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ANNE ARUNDEL General Hosp</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Writer</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Self Employed</b>                 |  |
| 13a. STATE<br><b>MD</b>  |   |   | 13b. COUNTY<br><b>A.A.</b>  | 13c. CITY OR TOWN<br><b>Edgewater</b>                                     | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>John B Hosford</b>   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Lillian Cunningham</b>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>UNKNOWN</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>487-14-4032</b>  | 17. INFORMANT ADDRESS<br><b>Reid Hosford 13E</b>                                  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest - multiple</b><br><b>4100</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Myocardial infarction</b><br>(c) <b>Coronary atherosclerosis</b> |   |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><b>Ductile myelitis</b>  |   |   |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)    |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/15</b> 19 <b>81</b> , to <b>11/22</b> 19 <b>81</b> , that (I/we) lost<br>saw the deceased die on <b>11/22</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I/we) (a) (b) (c) did not see the body after death.   |   |   |   |   |  |
| 22b. SIGNATURE<br><b>George Samaras</b>  |   | DEGREE<br><b>Attending Physician</b>  |   | 22c. DATE SIGNED<br><b>11/24/81</b>                                       |  |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>George Samaras</b>   |   | 23b. ADDRESS<br><b>205 Ridgely Ave. Annapolis</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   | 23b. DATE<br><b>11-23-81</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Cemetery</b>  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Baltimore Anne Arundel</b>          |   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>T. A. Hardesty Annapolis Md.</b>   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 23 1981</b>                               |   |  |

REGISTRAR'S SIGNATURE  
**Thomas J. Hardesty**



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in this office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |   |  | 8 1 2 7 9 1 4 |  |
|--|--|---|--|---|--|--|--|---|--|---------------|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.  |  |   |  |  |  |   |  |               |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Peter B. Jacobs</b>  |  |   |  |   |  | 20. DATE OF DEATH MONTH DAY YEAR<br><b>11 / 9 / 81</b>                                       |  | 2b. HOUR<br><b>6:45 P.M.</b>  |  |               |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Cau</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>4 / 24 / 95</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>86</b>  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pleasantville, New Jersey</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel</b> MD                               |  |   |  |               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Crownsville, Md.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Fairfield Nursing Center</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Carpenter</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |               |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |  |  |   |  |               |  |
| 13a. STATE<br><b>MD.</b>   |  | 13b. COUNTY<br><b>Anne Arundel</b>  |  | 13c. CITY OR TOWN<br><b>Annapolis</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1828 BURLEY LAKE</b>  |  |               |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>JOHN JACOBS</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>NANCY LIN KALOWN</b>   |  |  |  |   |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>YES</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>WW1 + WW2 # 133-01-6974</b>  |  | 17. INFORMANT ADDRESS<br><b>Nancy Lee - 1828 Burley La., Annap. Md.</b>                      |  |   |  |               |  |
| 18. CAUSE OF DEATH Enter only one cause per line (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory arrest</b><br><b>4360</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral Vascular accident</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>4 Wk</b><br>APPROXIMATE PERIOD BETWEEN ONSET AND DEATH |  |   |  |   |  |  |  |   |  |               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |   |  |   |  |  |  |   |  |               |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                         |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |  |               |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |               |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>Sept 10/30/81</b> to <b>Nov 8/81</b> , that (1) (we) last saw the deceased alive on <b>10/30/81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did not view the body after death.  |  |   |  |   |  |  |  |   |  |               |  |
| 22b. SIGNATURE<br><b>William C. Weintraub, M.D.</b>  |  | 22c. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22d. ADDRESS<br><b>104 Forbes St. Annap. Md.</b>  |  | 22e. DATE SIGNED<br><b>11/9/81</b>   |  | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>CREMATION</b>  |  | 23b. DATE<br><b>11-10-81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>FT. LINCOLN Crematory</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Brentwood Md.</b>                              |  |   |  |               |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Beall Funeral Home</b>   |  |   |  | 24b. ADDRESS<br><b>121-121st St., Annap. Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 12 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Van Winkle</b>  |  |               |  |

MEDICAL CERTIFICATION

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

81 27915

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |  |  |   |  |
|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>EDNA (NMN) JONES   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Nov 13 1981 |   |  | 2b. HOUR<br>M  |  |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Negro  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8-1898  |  | 6. AGE<br>(IN YEARS LAST BIRTHDAY)<br>83 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Md  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S. A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel MD.                             |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Annapolis  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Anne Arundel Gen'l Hosp. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                     |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>A.A.   |  | 13c. CITY OR TOWN<br>Crownsville  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1321 Sunrise Bch Rd.   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Henry Queen  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sallie Dicks   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>217-07-4530  |  | 17. INFORMANT<br>ADDRESS<br>Doris E. Oliver - Same As 13E   |  |  |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Pulmonary embolus<br>2506<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Phlebotrombosis left thigh<br>1 day<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Gangrene left foot.                 |  |   |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>Immediate  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>Generalized atherosclerosis, diabetes mellitus, left hemiparesis.   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br>12 Nov 81   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Gangrene left foot  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from Nov 12 1981 to Nov 13 1981, that (I) (the) last saw the deceased alive on Nov 12 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>Charles W. Kinzer   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br>13 Nov 1981   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CHARLES W. KINZER  |  |   |  | 22e. ADDRESS<br>Annapolis, Md.  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(BY)   |  | 23b. DATE<br>11-17-81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Hillcrest   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Annapolis A.A. Md                      |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>C. E. Hicks   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 20 1981  |  | 25b. REGISTRAR'S SIGNATURE<br>James Jean Weather                                     |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

MA

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Ann Arbor

A.A.

John Henry Brown

John Henry Brown

John Henry Brown

C.F. Hicks

11-1-61

Ann Arbor

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

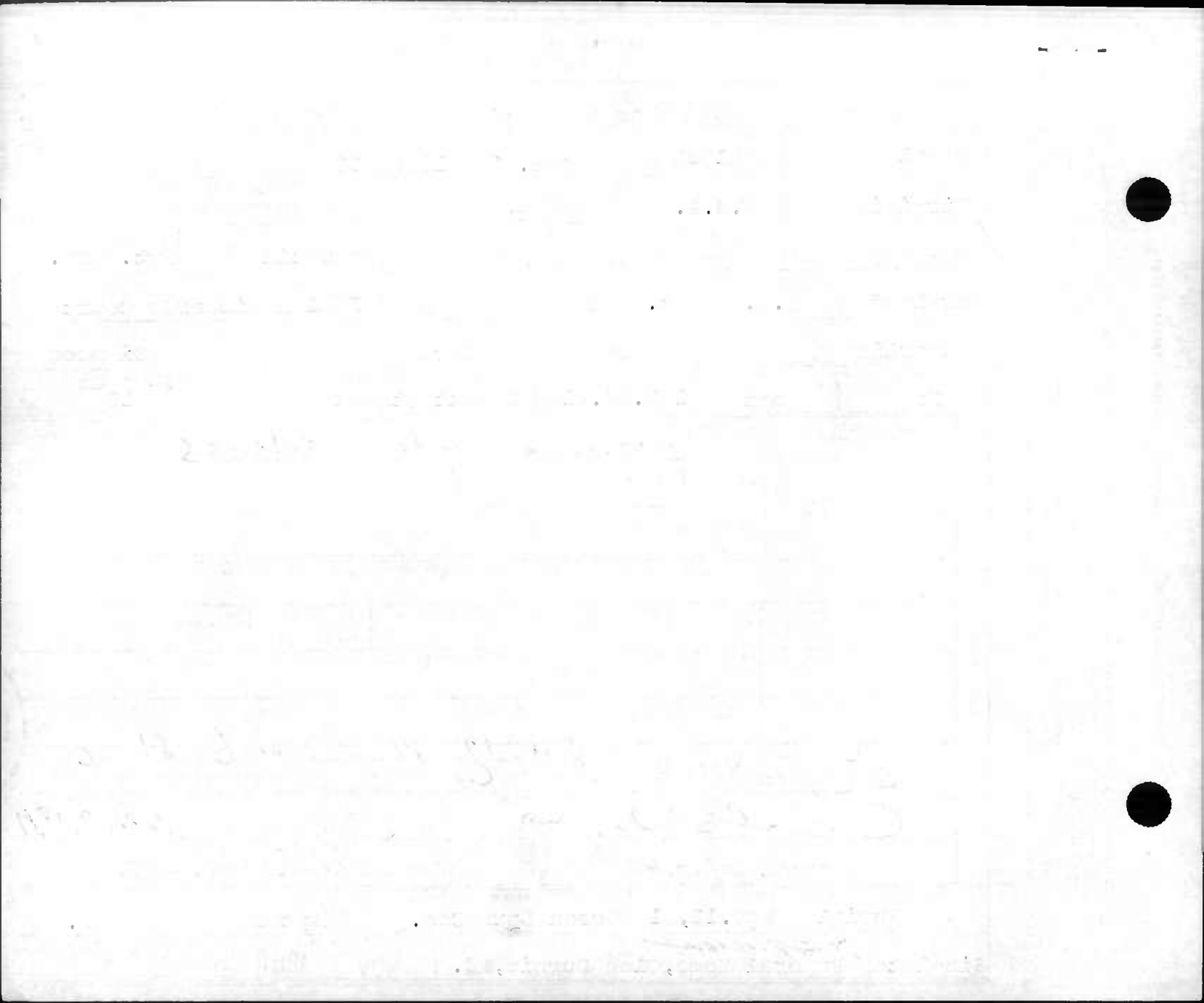
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  | 81 27916   |  |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |  |   |  |   |  |  |  | EST  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>FANNIE</b> <b>December</b> <b>JONES</b>   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 6, 1981</b>                                  |  |  |  | 2b. HOUR P.<br><b>2:55</b> <b>M</b>  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 25 1903</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY, MD.</b>                         |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Domestic</b>             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Pvt. Res.</b>  |  |  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>A.A.</b>   |  | 13c. CITY OR TOWN<br><b>Ft. Meade</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3041 A Richards Court</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charlie Akers</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Dora Simpson</b>  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>143.26.4148</b>   |  | 17. INFORMANT<br><b>Nephew</b>  |  | ADDRESS<br><b>Emmett Street</b>   |  | Same as <b>13</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>progressive systemic sclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>Nov. 6</b> 19 <b>81</b> to <b>Nov. 6</b> 19 <b>81</b> , that (1) (we) last saw the deceased alive on <b>Nov. 6</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.        |  |  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Charles J. Wu</b>   |  |  |  | DEGREE<br><b>MD</b>   |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>Nov. 7, 1981</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CHARLES J. WU, MD.</b>   |  |  |  | 22e. ADDRESS <b>7845 Oakwood Road, #204</b><br><b>Glen Burnie, Maryland, 21061</b>  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Nov. 12, 81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Green Lawn Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Hampton Va.</b>                                |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>H B Vinton</b> ADDRESS<br><b>Singleton Funeral Home, Glen Burnie, Md.</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 9 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. Wu</b>   |  |  |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

81 27917

1- FOR  
STATE  
REGISTRAR

REG. NO.

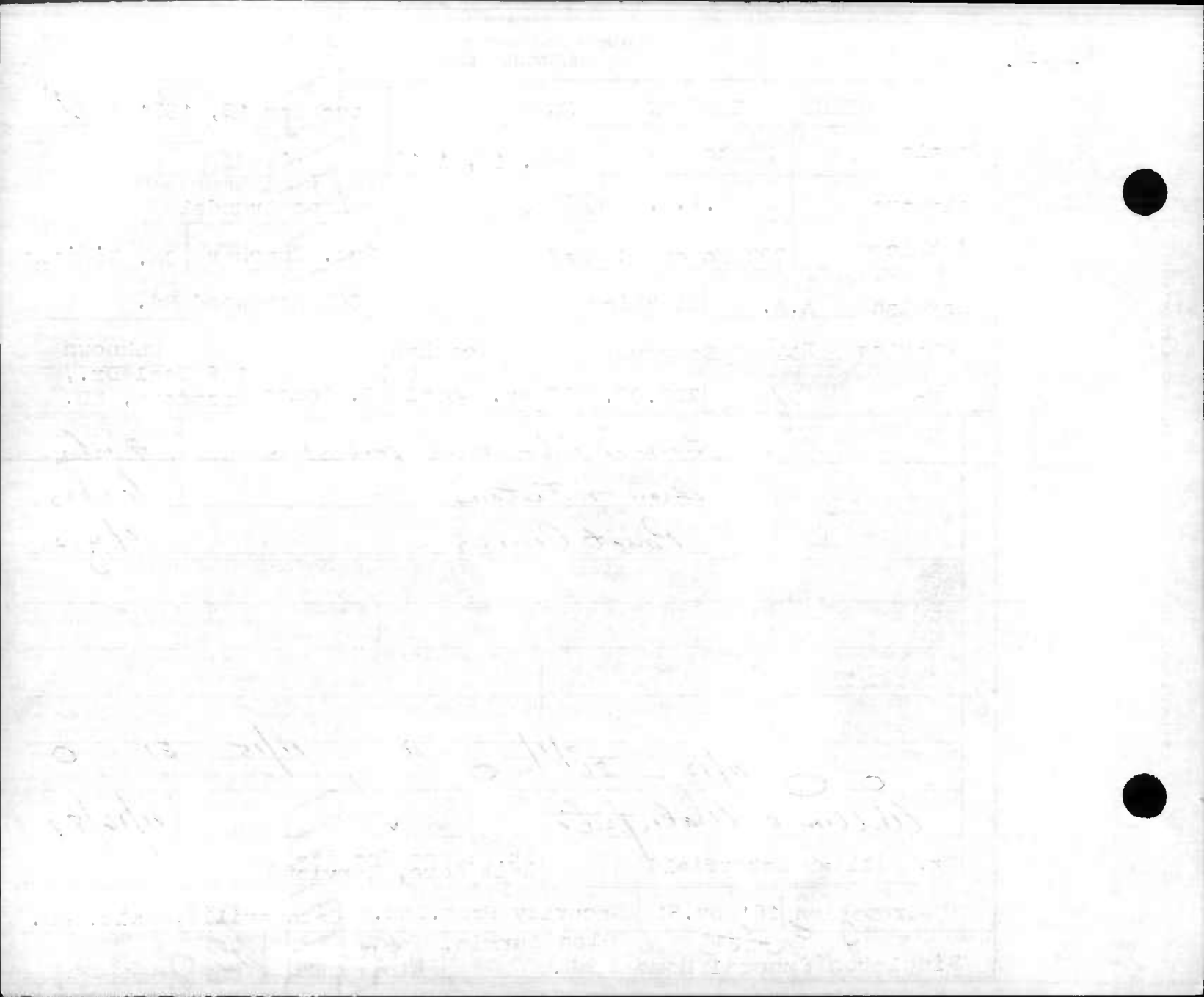
|  |                  |  |   |   |                                |  |  |
|--|------------------|--|---|---|--------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>GRACE SAMPSON JONES   |                  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 15, 1981        |   |                                | 2b. HOUR<br>6 P M  |  |
| 3. SEX<br>Female   | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 15, 1919  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>62 YRS.  |                                | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Delaware  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Linthicum   |                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>302 Homewood Road |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Sub. Teacher  |                                | 12b. KIND OF BUSINESS OR INDUSTRY<br>Co. Schools   |  |
| 13a. STATE<br>Maryland   |                  |  | 13b. COUNTY<br>A.A.   |   | 13c. CITY OR TOWN<br>Linthicum |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Ray Sampson  |                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Beulah unknown |   |                                |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |                  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br>N/A  |   | 17. INFORMANT (Son)<br>Mr. Donald C. Jones  |                                | ADDRESS<br>126 Teal Dr., Pasadena, MD.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Inward intracranial pressure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Brain metastases</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Brain Cancer</u> |                  |  |   |   |                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 wks</u><br><u>6 wks</u><br><u>4 yrs</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |                  |  |   |   |                                |  |  |
| 19a. DATE OF OPERATION   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/1/80</u> to <u>11/15/81</u> , that (I) <u>we</u> lost saw the deceased alive on <u>11/12/81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> (did) <u>not</u> view the body after death.   |                  |  |   |   |                                |  |  |
| 22b. SIGNATURE<br><u>William C. Waterfield</u>   |                  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |                                | 22c. DATE SIGNED<br><u>11/16/81</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. William Waterfield  |                  |  |   | 22e. ADDRESS<br>St. Agnes Hospital<br>Baltimore, Maryland   |                                |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |                  | 23b. DATE<br>16 Nov. 81  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Security Proc. Inc.   |                                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Catonsville, Balt. MD.   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>J. Easter<br>Singleton Funeral Home  |                  | ADDRESS<br>Glen Burnie, MD.  |   | 25a. DATE RECD. BY REGISTRAR<br>NOV 17 1981   |                                | 25b. REGISTRAR'S SIGNATURE<br><u>James J. Nathan</u>   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

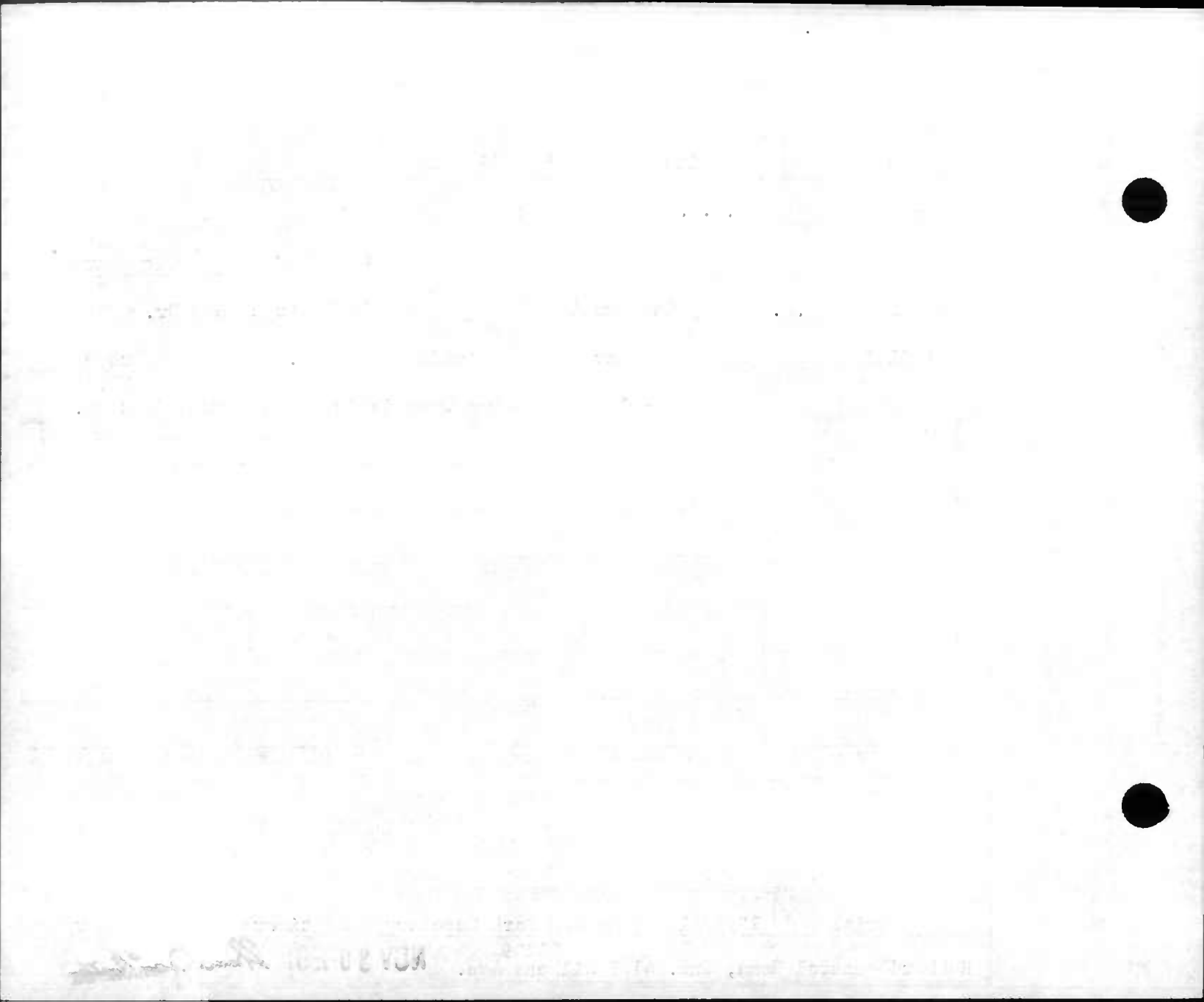
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of one.

DHMH - 16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |   |   |  |  |  | 8 1 2 7 9 1 8 |
|---|--|--|--|---|---|---|--|--|--|---------------|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.   |  |   |   | EST   |  |  |  |               |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HARRY MILTON KAHMER</b>  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 28, 1981</b> |   |  | 2b. HOUR P.<br>M.<br><b>10:10 P.</b>   |  |               |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 11 1900</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b>  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS.</b>   |  |               |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY, MD</b>                          |  |  |  |               |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Chauffer</b>             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Balto. City Bureau of Parks</b>  |  |               |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>A.A.</b>   |  | 13c. CITY OR TOWN<br><b>Glen Burnie</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>7907 Parke West Dr. 21061</b>  |  |               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Phillip Kahmer</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie C. Brown</b>   |  |   |   |   |  |  |  |               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218-01-3977</b>   |  | 17. INFORMANT ADDRESS<br><b>Norma Tyszkiewicz 7907 Parke West Dr. 21061</b>   |   |   |  |  |  |               |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4360</b> IMMEDIATE CAUSE (a) <b>cardiovascular accident</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost              |  |  |  |   |   |   |  |  |  |               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____  |  |  |  |   |   |   |  |  |  |               |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |               |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |  |  |               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |  |               |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>Nov. 27</b> , 19 <b>81</b> , to <b>Nov. 28</b> , 19 <b>81</b> , that (1) (we) lost<br>saw the deceased alive on <b>Nov. 28</b> , 19 <b>81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. (We) (I) (did) (did not) view the body after death. |  |  |  |   |   |   |  |  |  |               |
| 22b. SIGNATURE<br><b>Charles J. Wu</b>  |  | DEGREE<br><b>M.D.</b>  |  |   |   | 22c. DATE SIGNED<br><b>Nov. 29, 1981</b>  |  |  |  |               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CHARLES J. WU, M.D.</b>   |  | 22e. ADDRESS<br><b>7845 Oakwood Road, #204<br/>Glen Burnie, Maryland, 21061</b>  |  |   |   |   |  |  |  |               |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>12/2/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                         |  |  |  |               |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hubbard Funeral Home, Inc.</b>   |  | 24b. ADDRESS<br><b>4107 Wilkens Ave.</b>   |  | 24c. CITY OR TOWN<br><b>Baltimore</b>   |   | 24d. STATE<br><b>Maryland</b>   |  | 25. DATE REC'D. BY REGISTRAR<br><b>NOV 30 1981</b>   |  |               |
| 25. REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>  |  |  |  |   |   |   |  |  |  |               |

MEDICAL CERTIFICATION



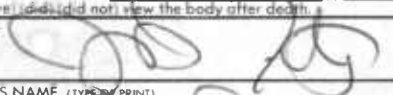
**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

REG. NO.

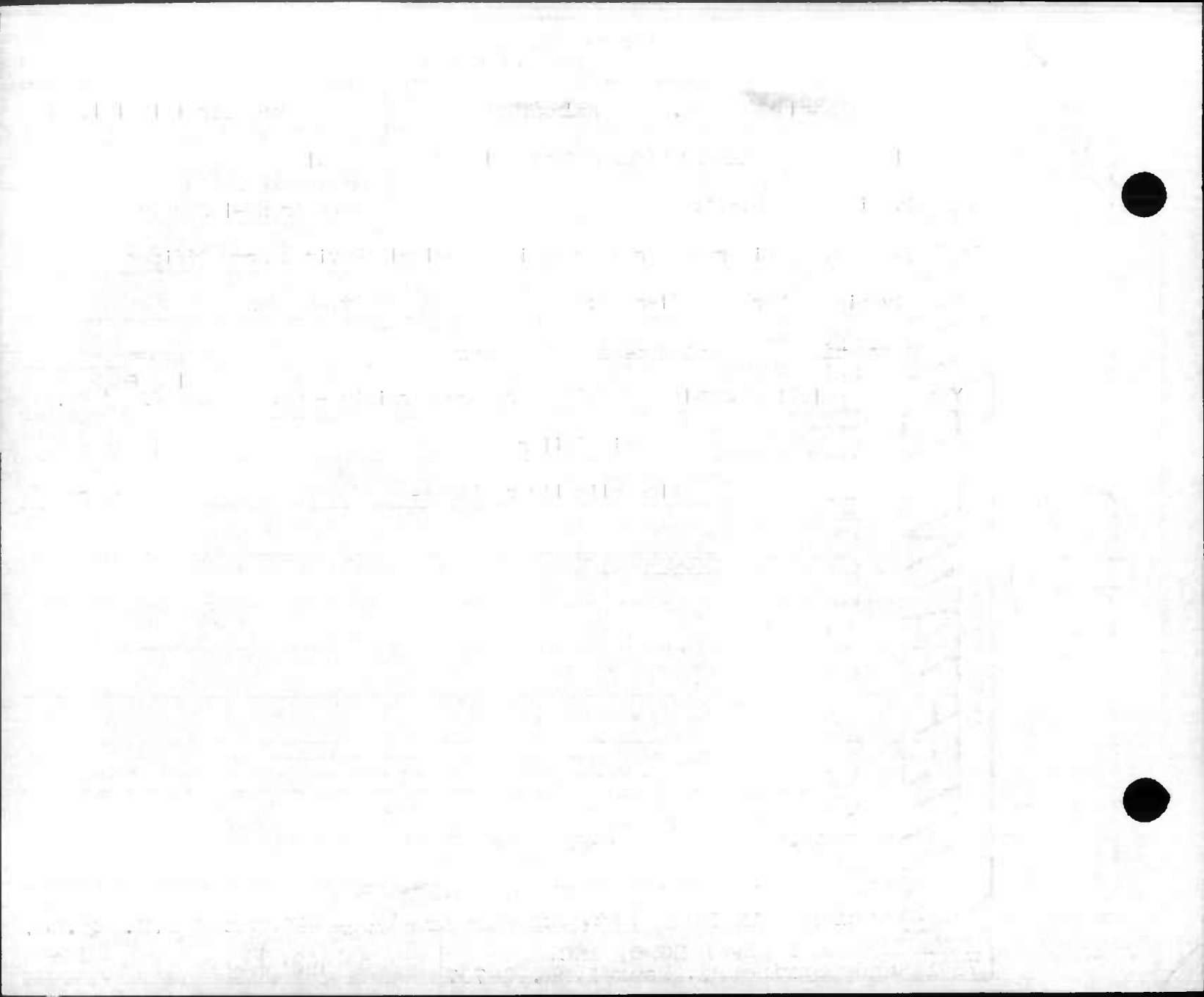
1- FOR  
STATE  
REGISTRAR

|  |  |   |  |  |   |
|--|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Joseph P. Karpicky  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 1 1981                                   |  | 2b. HOUR<br>1703p M   |
| 3. SEX<br>Male   | 4. RACE<br>XXXX White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept 17 30  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>51 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel County MD.                        |   |
| 10. CITY OR TOWN OF DEATH<br>Ft. Meade, Md.  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Kimbrough Army Community Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired Army Officer |  | 12b. KIND OF BUSINESS OR INDUSTRY                               |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Pennsylvania |  |   | 13b. COUNTY<br>York  | 13c. CITY OR TOWN<br>Glen Rock   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Konstanti Karpitski  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Bzom                               |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br>1971 Korea 159-24-6766  |  | 17. INFORMANT<br>ADDRESS<br>Glen Rock, Pa.<br>Gregory Karpicky - Rt. 2, Box 243, / Pa. |   |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Hepatic failure |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>10 days |
| 57/3<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   | (b) DUE TO, OR AS A CONSEQUENCE OF<br>Alcoholic liver disease  | 8 years  |
|  | (c) DUE TO, OR AS A CONSEQUENCE OF   |  |
|  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a |  |

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE<br>   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>James D. Furzmo  |  | 22e. ADDRESS   |  |   |  |

|  |                      |   |  |
|--|----------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation  | 23b. DATE<br>11/3/81 | 23c. NAME OF CEMETERY OR CREMATORY<br>Ft. Lincoln Crematory | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brentwood P.G. Co. Md. |
| 24. FUNERAL DIRECTOR<br>FLECK LAUREL FUNERAL HOME, INC.<br>7601 Sandy Spring Rd. Laurel, Md. 20707 |                      | 25a. DATE REC'D. BY REGISTRAR<br>NOV 4 1981                 |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

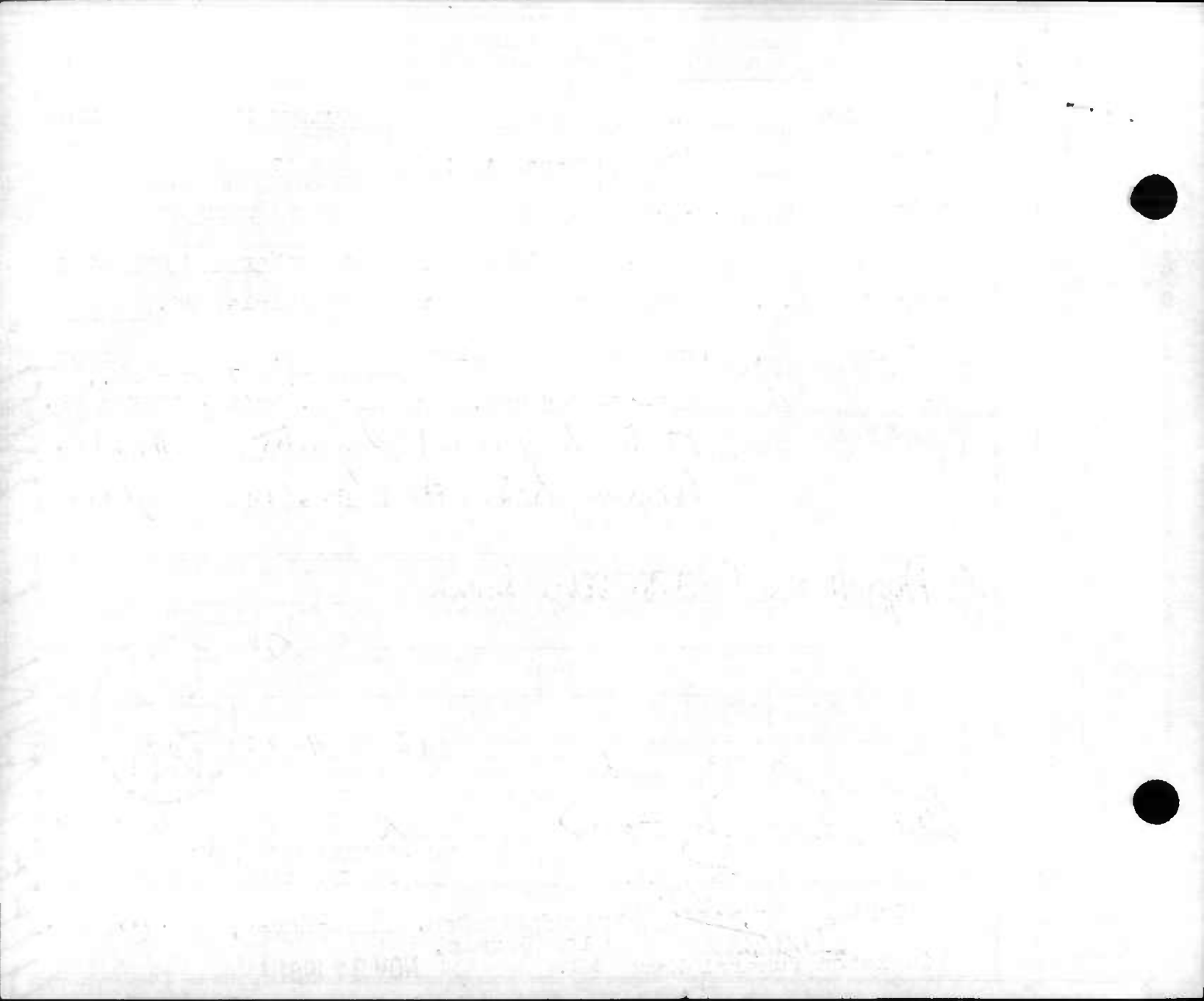
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 9 2 0

|   |  |   |  |   |                       |  |
|---|--|---|--|---|-----------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>CORA EDNA KELLY   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 23, 1981 |   | 2b. HOUR P<br>12:00 M |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>March 1, 1894   |                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS.  |                       |  |
| 10. CITY OR TOWN OF DEATH<br>GLEN BURNIE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NORTH ARUNDEL HOSPITAL |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ANNE ARUNDEL COUNTY MD.                                 |                       |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home   |  |   |                       |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>A.A.   |  | 13c. CITY OR TOWN<br>Linthicum  |                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Sedgwick T. Pumphrey  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Alice L. Rider   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A  |  | 17. INFORMANT (Daughter) ADDRESS<br>7 Luna Ln.,<br>Mrs. Isabelle K. Smith, Severna Pk.          |                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>4:00 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>Cerebral Artery Heart Dissection</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Minutes</u><br><u>Years</u> |  |   |  |   |                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Hyperthrombosis</u> <u>Arterio Sclerosis</u>  |  |   |  |   |                       |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |                       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>63 4-23 81                                 |                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 63 to 11-23 81, that (I) (we) lost the deceased alive on 11-23 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |                       |  |
| 22b. SIGNATURE<br><u>Hilary T. O'Herlihy, M.D.</u>  |  | DEGREE<br>M.D.  |  | 22c. DATE SIGNED<br>11-23-81  |                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>HILARY T. O'HERLIHY, M.D.  |  | 22e. ADDRESS<br>325 HOSPITAL DRIVE, #208<br>GLEN BURNIE, MARYLAND 21061   |  |   |                       |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>NOV. 27, 1981  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Friendship Cem.   |                       |  |
|   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Hanover A.A., MD.                                 |                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Singleton Funeral Home  |  | ADDRESS<br>Glen Burnie, MD.   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 27 1981  |                       |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>James J. [Signature]</u>                                       |                       |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 9 2 1

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |                                |  |
|--|--|--|--|---|--------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>George H. Kirby   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>11 - 23 - 81 |   | 2b. HOUR<br>10 <sup>5</sup> PM |  |
| 3. SEX<br>Male   |  | 4. RACE<br>#2  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>4 - 8 - 31   |                                | 6. AGE (IN YEARS LAST BIRTHDAY)<br>50 YRS.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel MD.   |
| 10. CITY OR TOWN OF DEATH<br>Annapolis   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>A.A. General  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Comm. Fisherman   |                                | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY<br>Anne Arundel  |  | 13c. CITY OR TOWN<br>Annapolis  |                                | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Thomas Kirby  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Hannah Gross   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>IND   |                                | 16b. SOCIAL SECURITY NO.<br>L  |
| 17. INFORMANT ADDRESS<br>William Kirby - Annapolis, Md.  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ca ESOPHAGUS</u><br>1509<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |  |   |                                |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/17/81</u> , 19 <u>81</u> , to <u>11/23/81</u> , 19 <u>81</u> , that (I) <del>(we)</del> lost<br>saw the deceased alive on <u>11/23/81</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) <del>(we)</del> did not view the body after death. |  |  |  |   |                                |  |
| 22b. SIGNATURE<br>SP Watkins   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  | 22c. DATE SIGNED<br>11/23/81  |                                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>STANLEY WATKINS   |  | 22e. ADDRESS   |  |   |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>11/28/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Pine Lawn Mem'l   |                                |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Annapolis AA MD  |  | 23e. DATE REC'D BY REGISTRAR<br>NOV 27 1981  |  |   |                                |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>William Reese & Sons Mortuary - Annapolis, Md.   |  |  |  |   |                                |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained for 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |                                  | 8 1 2 7 9 2 2  | REG. NO.  | E.S.T. |
|--|--|---|--|---|--|--|--|--|----------------------------------|--|---|--------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>IRMA RUTH KNIGHT   |  |   |  |   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 27, 1981       |  | 2b. HOUR<br>7:08 AM              |  |   |        |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JULY 11, 1905   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. 76                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |                                  | IF UNDER 24 HRS<br>HOURS MIN.  |   |        |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ANNE ARUNDEL COUNTY MD.                |  |  |                                  |  |   |        |
| 10. CITY OR TOWN OF DEATH<br>GLEN BURNIE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NORTH ARUNDEL HOSPITAL |  |   |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>(RET) HAT MAKER  |                                  | 12b. KIND OF BUSINESS OR INDUSTRY<br>MENS HAT FACTORY  |   |        |
| 13a. STATE<br>MARYLAND   |  |   |  |   |  |  | 13b. COUNTY<br>A.A. CO.  |  | 13c. CITY OR TOWN<br>GLEN BURNIE |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |        |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>WILLIAM CHARLES KNIGHT   |  |   |  |   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>BEULAH HURLEY |  |                                  |  |   |        |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A  |  | 17. INFORMANT<br>ADDRESS SAME AS # 13<br>MRS. CARRIE ALTHEA RILEY (SISTER)     |  |  |                                  |  |   |        |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiovascular aortic</u><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>AD 140 -</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) |  |   |  |   |  |  |  |  |                                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |        |
| MEDICAL CERTIFICATION  |  |   |  |   |  |  |  |  |                                  |  |   |        |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |        |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |                                  |  |   |        |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |                                  |  |   |        |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12/1/80</u> 19 <u>80</u> , to <u>11/27/81</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>11/27/81</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If deceased did not view the body after death.)  |  |   |  |   |  |  |  |  |                                  |  |   |        |
| 22a. SIGNATURE<br><u>Jorge Ramirez</u>   |  |   |  |   |  | DEGREE<br>M.D.   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                                  | 22c. DATE SIGNED<br>11/27/81   |   |        |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JORGE RAMIREZ, M.D.   |  |   |  |   |  | 22d. ADDRESS<br>7845 OAKWOOD ROAD SUITE 205<br>GLEN BURNIE, MARYLAND 21061     |  |  |                                  |  |   |        |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  |   |  | 23b. DATE<br>30 NOV '81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GLEN HAVEN MEM. PK.                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>GLEN BURNIE A.A. MD.   |                                  |  |   |        |
| 24. FUNERAL DIRECTOR<br><u>Singleton</u><br>SINGLETON FUNERAL HOME, ADDRESS GLEN BURNIE, MD.   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 1 1981                                    |  |  |                                  |  |   |        |
|  |  |   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>James San Nathan</u>                          |  |  |                                  |  |   |        |

BP



WINE MARKET COUNTRY

OLD BEERIE NORTH AMERICAN HOSPITAL

ALPHABETICALLY

11-2011

11-2011

11-2011

11-2011

2845 CINCINNATI ROAD SOUTH  
CINCINNATI, OHIO 45228

W. J. ROBERTSON, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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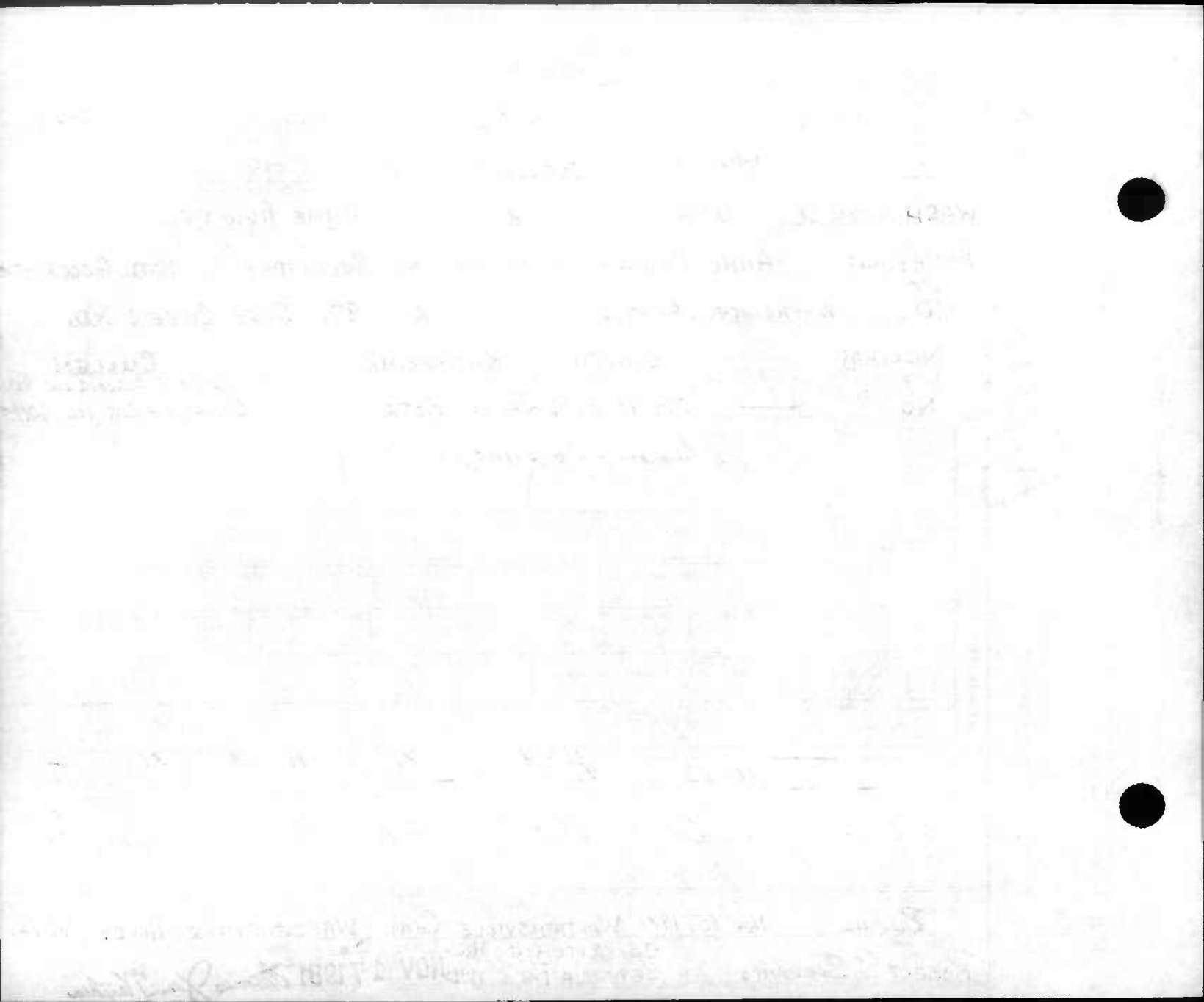
1. FOR  
STATE  
REGISTER

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Regina S Kotz</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 13, 1981</b>                      |   | 2b. HOUR<br><b>3:40 P.M.</b>                                 |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>OCTOBER 30, 1903</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WASHINGTON, DC.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL</b> MD.                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>ANNAPOLIS</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ANNE ARUNDEL GEN. HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SECRETARY</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>NATL. GEOGRAPHIC</b> |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>ANNE ARUNDEL</b>  | 13c. CITY OR TOWN<br><b>ARNOLD</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>971 DEEP CREEK RD.</b>             |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WILLIAM SMITH</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>KATHERINE CULLEN</b>  |  | ADDRESS<br><b>1224 E. ALBONQUIN RD. SCHAMBURG, ILL. 60955</b>                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>579 48 8206</b>  |  | 17. INFORMANT<br><b>JAMES KOTZ</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>renal failure</b><br><b>5-860</b> DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) <u>the hospital</u> attended the deceased from <u>11-4</u> , 19 <u>81</u> , to <u>11-13</u> , 19 <u>81</u> , that (I) <u>was</u> last saw the deceased alive on <u>11-13</u> , 19 <u>81</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I <u>did</u> <u>did not</u> ) view the body after death. |  |   |  |   |  |
| 22b. SIGNATURE<br><i>[Signature]</i>  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>11/13/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert S. Barranco</b>  |  | 22e. ADDRESS<br><b>501 RITCHIE Hwy SEVERNA PARK, MD</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>Nov. 15, 1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WARDENSVILLE CEM.</b>                                  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>WARDENSVILLE HARDY W.VA.</b>   |  | 24. FUNERAL DIRECTOR<br>NAME<br><b>ROBERT S. BARRANCO</b>   |  |   |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 17 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |   |  | 8 1 2 7 9 2 4 |
|--|--|---|--|---|--|--|--|---|--|---------------|
| 1 - FOR STATE REGISTRAR  |  | REG. NO.  |  |   |  |  |  | EST   |  |               |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JAMES ALBERT KRAFT, Sr.</b>  |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOVEMBER 12, 1981</b>   |  | 2b. HOUR<br><b>6:20 P.M.</b>  |  |               |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>3/4/1920</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS.  |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |               |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD.</b>   |  |   |  |               |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Machine Operator</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>J.E. Smith</b>  |  |               |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>A.A. Co.</b>  |  | 13c. CITY OR TOWN<br><b>Glen Burnie</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>7036 Shoreland Drive</b>  |  |               |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>George KRAFT</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Katherine Roche</b>  |  |  |  |   |  |               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>216-09-1805</b>  |  | 17. INFORMANT<br><b>Mrs. Eleanor M. Kraft</b>   |  | ADDRESS<br><b>Same as #13</b>  |  |   |  |               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br><b>4290</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>myocarditis</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |  |  |   |  |               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>   |  |   |  |   |  |  |  |   |  |               |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |               |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |               |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |               |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 19 79</b> to <b>SEP 81</b> , that (I) (we) last saw the deceased alive on <b>SEPT 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |   |  |               |
| 22b. SIGNATURE<br><b>Lorraine M. Dailey M.D.</b>   |  |   |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/12/81</b>   |  |               |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LORRAINE DAILEY, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>8667 FT. SMALLWOOD ROAD, PASADENA, MD.</b>   |  |  |  |   |  |               |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/16/1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Pk.</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Glen Burnie, A.A. Co., Md.</b>   |  |   |  |               |
| 24. FUNERAL DIRECTOR NAME<br><b>McGully Funeral Home</b>   |  |   |  | ADDRESS<br><b>Balto. Md., 21225 237 E. Patapsco Ave.,</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 17 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Martin</b>  |  |               |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death.

with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  | 8 1 2 7 9 2 5  | EST |                                   |          |                     |  |
|---|--|--|--|---|--|--|--|--|--|--|-----|-----------------------------------|----------|---------------------|--|
| 1. DECEASED NAME  |  |  |  |   |  |  |  |  |  | 2a. DATE OF DEATH  |     |                                   |          | 2b. HOUR            |  |
| FIRST MIDDLE LAST   |  |  |  |   |  |  |  |  |  | MONTH  | DAY | YEAR                              | 7b. HOUR |                     |  |
| ROBERT LEROY KROEDEL, SR.   |  |  |  |   |  |  |  |  |  | NOVEMBER 17, 1981  |     |                                   |          | 6:29 A <sub>M</sub> |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  |  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))  |  | IF UNDER 1 YEAR  |     | IF UNDER 24 HRS                   |          |                     |  |
| Male  |  | White  |  | Frb. 6, 1932  |  |  |  | 49 YRS.  |  | MONTHS DAYS  |     | HOURS MIN.                        |          |                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |     |                                   |          |                     |  |
| Maryland  |  | U.S.A.   |  |   |  |  |  | ANNE ARUNDEL COUNTY MD.  |  |  |     |                                   |          |                     |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |     | 12b. KIND OF BUSINESS OR INDUSTRY |          |                     |  |
| GLEN BURNIE   |  | NORTH ARUNDEL HOSPITAL   |  |   |  |  |  |  |  | Plumber  |     | Plumbing                          |          |                     |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS  |  |  |     |                                   |          |                     |  |
| Maryland  |  | A. A.  |  | Glen Burnie   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 305 Cathedral Place  |  |  |     |                                   |          |                     |  |
| 14. FATHER'S NAME   |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |  |  |  |     |                                   |          |                     |  |
| FIRST MIDDLE LAST   |  |  |  | FIRST MIDDLE LAST   |  |  |  |  |  |  |     |                                   |          |                     |  |
| Frederick Frank Kroedel   |  |  |  | Amelia Martha Hocler  |  |  |  |  |  |  |     |                                   |          |                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  |  |  | ADDRESS  |     |                                   |          |                     |  |
| no  |  |  |  | 215-28-5952   |  | Elaine M. Kroedel  |  |  |  | same as above  |     |                                   |          |                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:   |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |     |                                   |          |                     |  |
| IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>   |  |  |  |   |  |  |  |  |  |  |     |                                   |          |                     |  |
| 4100 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |  |  |  |  |  |     |                                   |          |                     |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |   |  |  |  |  |  |  |     |                                   |          |                     |  |
| (b) <u>Massive myocardial infarction</u>  |  |  |  |   |  |  |  |  |  |  |     |                                   |          |                     |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |  |  |  |  |  |     |                                   |          |                     |  |
| (c) <u>Persistent congestive heart failure</u>  |  |  |  |   |  |  |  |  |  |  |     |                                   |          |                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |  |   |  |  |  |  |  |  |     |                                   |          |                     |  |
| <u>Arteriosclerosis. Emphysema. Extensive atherosclerosis.</u>  |  |  |  |   |  |  |  |  |  |  |     |                                   |          |                     |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |     |                                   |          |                     |  |
|   |  |  |  |   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |     |                                   |          |                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) |  |  |  |  |     |                                   |          |                     |  |
|   |  |  |  | HOUR A.M. MONTH DAY YEAR  |  |  |  |  |  |  |     |                                   |          |                     |  |
|   |  |  |  | P.M. 19   |  |  |  |  |  |  |     |                                   |          |                     |  |
| 21d. INJURY OCCURRED  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION  |  |  |  |  |     |                                   |          |                     |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  |   |  | STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |     |                                   |          |                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>74</u> , to <u>present</u> , 19 _____, that (I) (we) last saw the deceased alive on <u>11/13/81</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |  |     |                                   |          |                     |  |
| 22b. SIGNATURE  |  |  |  | DEGREE  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |     |                                   |          |                     |  |
| <u>Nicholas P. Moutsos</u>  |  |  |  | MD  |  |  |  |  |  | 11/17/81   |     |                                   |          |                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS  |  |  |  |  |  |  |     |                                   |          |                     |  |
| NICHOLAS P. MOUTSOS, M.D.   |  |  |  | 95 AQUAHART ROAD<br>GLEN BURNIE, MARYLAND, 21061  |  |  |  |  |  |  |     |                                   |          |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  | 23d. LOCATION  |     |                                   |          |                     |  |
| Burial  |  |  |  | 11/20/1981  |  | Meadowridge Cem.   |  |  |  | Baltimore, Maryland  |     |                                   |          |                     |  |
| 24. FUNERAL DIRECTOR  |  |  |  |   |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR                                  |     | 25b. REGISTRAR'S SIGNATURE        |          |                     |  |
| NAME ADDRESS  |  |  |  |   |  |  |  |  |  | NOV 18 1981  |     | <u>James J. [Signature]</u>       |          |                     |  |
| Raymond C. Fink Glen Burnie, Md.  |  |  |  |   |  |  |  |  |  |  |     |                                   |          |                     |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 9 2 6

REG. NO.

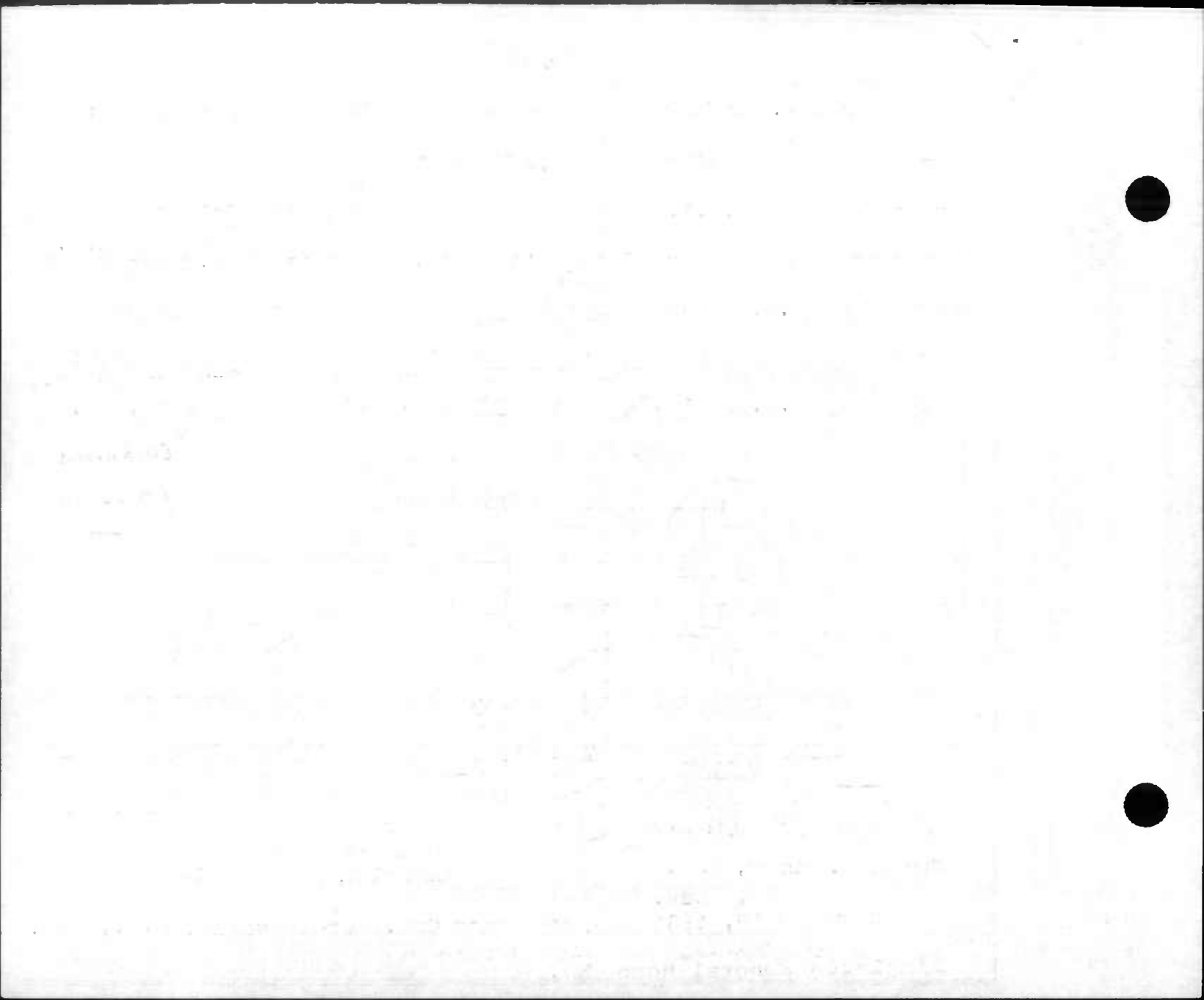
|   |   |  |   |  |                                   |
|---|---|--|---|--|-----------------------------------|
| 1. FOR STATE REGISTRAR  |   | 2a. DATE OF DEATH  |   | 2b. HOUR   |                                   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   | 2a. DATE OF DEATH  |   | 2b. HOUR   |                                   |
| Frank John Kuczinski  |   | November 9, 1981   |   | 9:52 a.m.  |                                   |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | IF UNDER 1 YEAR  |                                   |
| Male  | White   | Aug. 13, 1927  | 54 YRS.   | IF UNDER 24 HRS.   |                                   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                   |
| Maryland  | U.S.A.  |  | Anne Arundel County, MD.  |  |                                   |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| Annapolis   | Anne Arundel Gen'l. Hosp.   |  | Carrier (Ret.)  |  | Post Office                       |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   |  |   |  |                                   |
| 13a. STATE  | 13b. COUNTY   | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS  |                                   |
| Maryland  | A.A.  | Annapolis  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | Madison Avenue   |                                   |
| 14. FATHER'S NAME   |   | 15. MOTHER'S MAIDEN NAME   |   |  |                                   |
| Steve Kuczinski   |   | Genevieve Andrzeki   |   |  |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT (Brother) ADDRESS  |                                   |
| Yes   |   | W.W.II 212.24.9668   |   | 780 Jennie Dr.,<br>Andrew M. Kuczinski, Severn, MD.                            |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |   |  |   |  |                                   |
| PART I. DEATH WAS CAUSED BY:  |   |  |   |  |                                   |
| IMMEDIATE CAUSE (a) Heart failure   |   |  |   |  |                                   |
| DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension   |   |  |   |  |                                   |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____  |   |  |   |  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c):  |   |  |   |  |                                   |
|   |   |  |   |  |                                   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?  |                                   |
|   |   |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |                                   |
|   |   | P.M. 19  |   |  |                                   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |                                   |
|   |   |  |   |  |                                   |
| 22a. I certify that (I) (the hospital) attended the deceased from 7/26/81, 19____, to 11/9/81, 19____, that (I) (we) lost saw the deceased alive on 8/15/81, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |   |  |   |  |                                   |
| 22b. SIGNATURE  |   | DEGREE   |   | 22c. DATE SIGNED   |                                   |
| Charles W. Kinzer   |   |  |   | 11/10/81   |                                   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |   | 22e. ADDRESS   |   |  |                                   |
| Charles W. Kinzer, M. D.  |   | 16 Murray Avenue<br>Annapolis, Maryland 21401  |   |  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |   | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |                                   |
| Burial  |   | Nov. 13, 1981  |   | MD. Veterans Cem.  |                                   |
|   |   |  |   | Crownsville, A.A. MD.  |                                   |
| 24. FUNERAL DIRECTOR'S NAME   |   | 24b. ADDRESS   |   | 25a. DATE REC'D. BY REGISTRAR  |                                   |
| R. H. Hopkins   |   | Glen Burnie MD.  |   | NOV 12 1981  |                                   |
|   |   |  |   | 25b. REGISTRAR'S SIGNATURE   |                                   |
|   |   |  |   | Francis J. Nathan  |                                   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked ar item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/B1  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

81 27927

REG. NO.

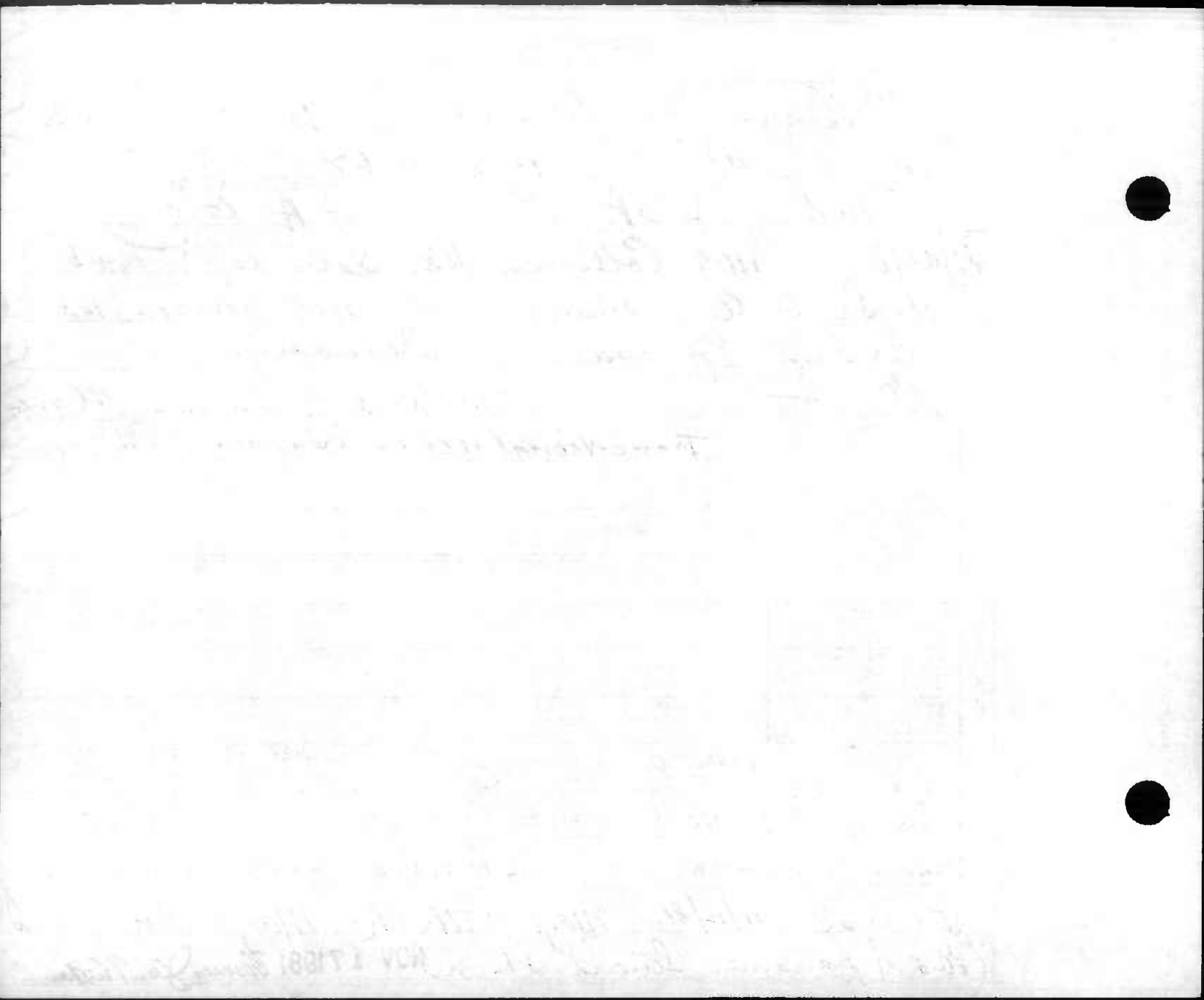
1 - FOR  
STATE  
REGISTRAR

|  |  |   |  |   |   |
|--|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>William J. Lamm</i>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <i>11-13-81</i>   |   | 2b. HOUR <i>11:00 AM</i>                                |
| 3. SEX <i>M</i>  | 4. RACE <i>W</i>   | 5. DATE OF BIRTH MONTH DAY YEAR <i>1-2-1967</i>   | 6. AGE (IN YEARS LAST BIRTHDAY) <i>67</i> YRS.   |   | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD</i>  | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>AA</i> MD.   |   |   |
| 10. CITY OR TOWN OF DEATH <i>Maryd</i>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>1109 Collison Rd</i> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Sales Rep</i>               | 12b. KIND OF BUSINESS OR INDUSTRY <i>Food</i> |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <i>MD</i> | 13b. COUNTY <i>AA</i>  | 13c. CITY OR TOWN <i>Maryd</i>  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Andrew J. Lamm</i>  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Bernadine</i>  |   | 13e. STREET ADDRESS <i>1109 Collison Rd</i>  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR IN (OWN)) <i>NO</i>                           | 16b. SOCIAL SECURITY NO. <i>-</i>  | 17. INFORMANT ADDRESS <i>Mildred E. Lamm - Above</i>  |  |   |   |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><i>1889</i> IMMEDIATE CAUSE (a) <i>Transitional cell Ca Bladder</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 years</i> |
|--|--|---|

|   |  |  |   |
|---|--|--|---|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>9</i>   |  |  |   |
| 19a. DATE OF OPERATION <i>9</i>   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                 | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>           | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>1980</i> to <i>NOV 13, 1981</i> , that (1) (we) last saw the deceased alive on <i>November 1981</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE <i>David S. McHold</i>   | DEGREE <i>MD</i>   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED <i>11/14/81</i>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DAVID S MCHOLD</i>   | 22e. ADDRESS <i>16 MURRAY AVE, ANNAPOLIS MD 21401</i>            |  |   |

|   |                           |   |  |
|---|---------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL <i>Burial</i> | 23b. DATE <i>11/16/81</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Maryd Muth Ch</i> | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Maryd AA MD</i> |
| 24. FUNERAL DIRECTOR <i>Robert S. Lamm</i>    |                           | 25a. DATE REC'D. BY REGISTRAR <i>NOV 17 1981</i>        | 25b. REGISTRAR'S SIGNATURE <i>Frances Jean Whitham</i>     |

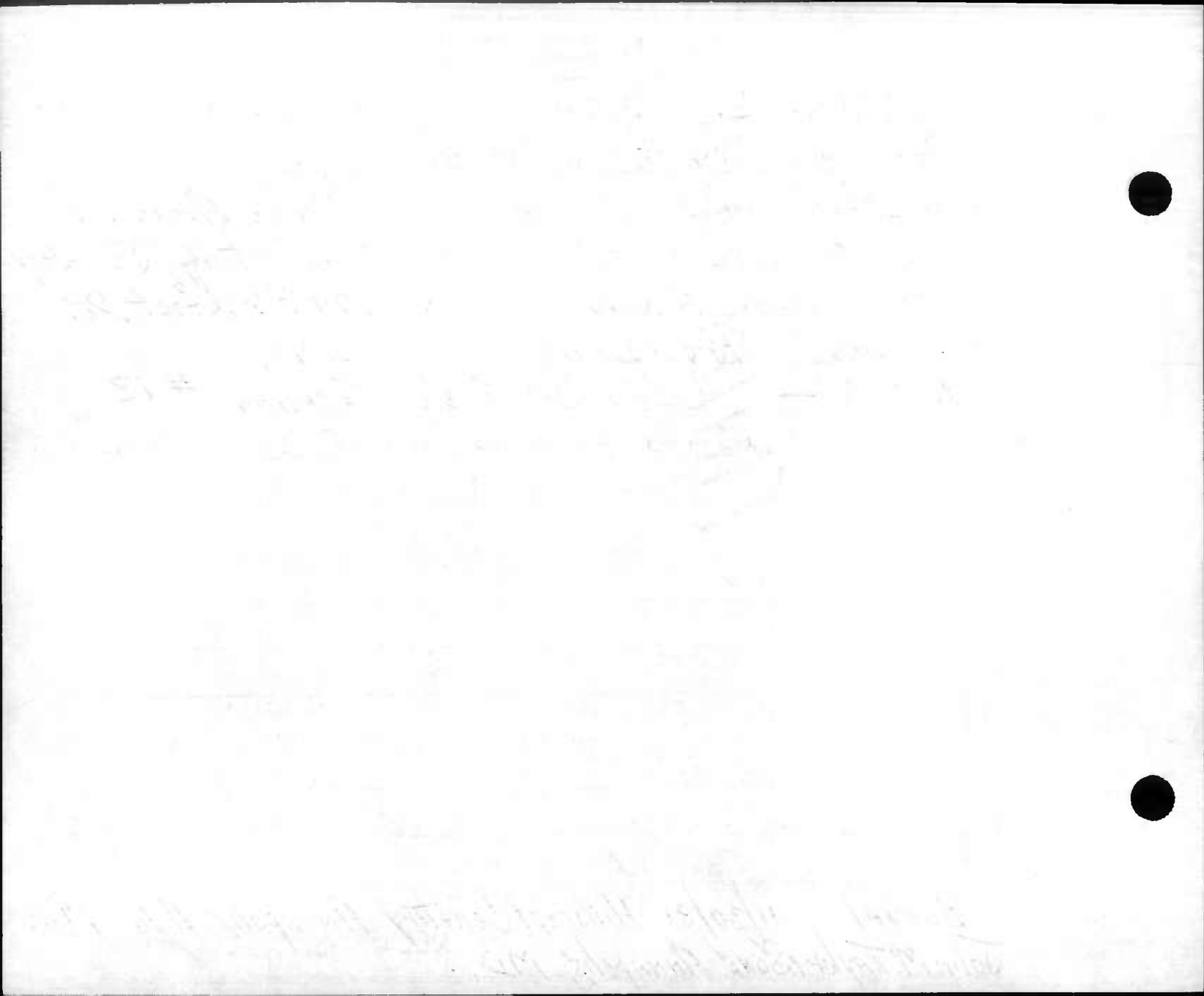


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| FOR<br>1. STATE<br>REGISTRAR  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  | 8 1 2 7 9 2 8<br>REG. NO.  |   |
|---|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HILDA L. LANNI</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11-28-81</b>  |  | 2b. HOUR<br><b>12 P</b>   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>11 18 09</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS                                     |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Rhode Island</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel MD</b>                       |   |
| 10. CITY OR TOWN OF DEATH<br><b>Annapolis</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Anne Arundel General</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Manufacturing Jewellery</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><b>MD</b>   | 13b. COUNTY<br><b>A.A.</b>   | 13c. CITY OR TOWN<br><b>Arnold</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    | 13e. STREET ADDRESS<br><b>109 Blackfoot Dr.</b>                                      |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Carmino Procaccini</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>UNK</b>  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>035-20-6943</b>  |  | 17. INFORMANT ADDRESS<br><b>Evelyn Taralian #13</b>                                  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a): <b>cardiopulmonary arrest</b><br><b>1519</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b): <b>gasmic cardiovascular embolus</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c):<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 minutes</b> |  |   |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>malnutrition</b>   |  |   |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                      |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 15</b> , 19 <b>80</b> , to <b>Nov 28</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>Oct 2</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |   |
| 22b. SIGNATURE<br><b>Attended by Tim Chacaras</b>   |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>            |  | 22c. DATE SIGNED<br><b>11/28/81</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>A. PLUCIS / J. CHACARAS</b>   |  | 22e. ADDRESS<br><b>1521 RITCHE HGT.</b>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   | 23b. DATE<br><b>11/30/81</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Annapolis, A.A. MD</b>              |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John M. Taylor &amp; Sons</b>  |  | ADDRESS<br><b>Annapolis, MD.</b>  |  |  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_  
DHMM - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 9 2 9

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |   |   |  |   |                     |
|--|---|---|--|---|---------------------|
| 1. DECEASED NAME<br>(TYPE OF NAME)<br><del>John William LeGore, Jr</del> John William LeGore, Jr |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 14 81  |   | 2b. HOUR<br>2:45 PM |
| 3. SEX<br>Male   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8-24-15   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel MD.   |   |                     |
| 10. CITY OR TOWN OF DEATH<br>Annapolis   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Anne Arundel General |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Owner                                | 12b. KIND OF BUSINESS OR INDUSTRY<br>Tavern |                     |
| 13a. STATE<br>MD   | 13b. COUNTY<br>A.A.   | 13c. CITY OR TOWN<br>Annapolis  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>          | 13e. STREET ADDRESS<br>822 Chester Avenue   |                     |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John William LeGore Sr                                 | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Estella Rittase  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No - |   |                     |
| 16b. SOCIAL SECURITY NO.<br>199-03-0628  |   | 17. INFORMANT<br>Mary Young LeGore  |  | ADDRESS<br>Same as #13                      |                     |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction<br>5742<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)  |  |   |

|  |  |   |  |  |   |
|--|--|---|--|--|---|
| 19a. DATE OF OPERATION<br>11/13/81   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Cholecystitis             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |  |   |
| 22a. I certify that (1) this hospital attended the deceased from 11-10-1981 to 11-14-1981, that (1) we lost<br>saw the deceased alive on 11-13-1981, and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above. (1) (we) (I) (did not) view the body after death. |  |   |  |  |   |
| 22b. SIGNATURE<br>Barber C. Palmer, M.D.   |  | DEGREE<br>M.D.  |  | 22c. DATE SIGNED<br>11-16-81   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS<br>801 Melvin Avenue, Annapolis, MD 21401                        |  |  |   |

|  |                            |  |   |
|--|----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                       | 23b. DATE<br>Nov. 17, 1981 | 23c. NAME OF CEMETERY OR CREMATORY<br>Trinity Lutheran | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Taneystown Carroll MD |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Taylor Funeral Chapel, Annapolis, MD |                            | 25a. DATE REC'D. BY REGISTRAR<br>NOV 18 1981           |   |
|  |                            | 25b. REGISTRAR'S SIGNATURE<br>James Santhos            |   |



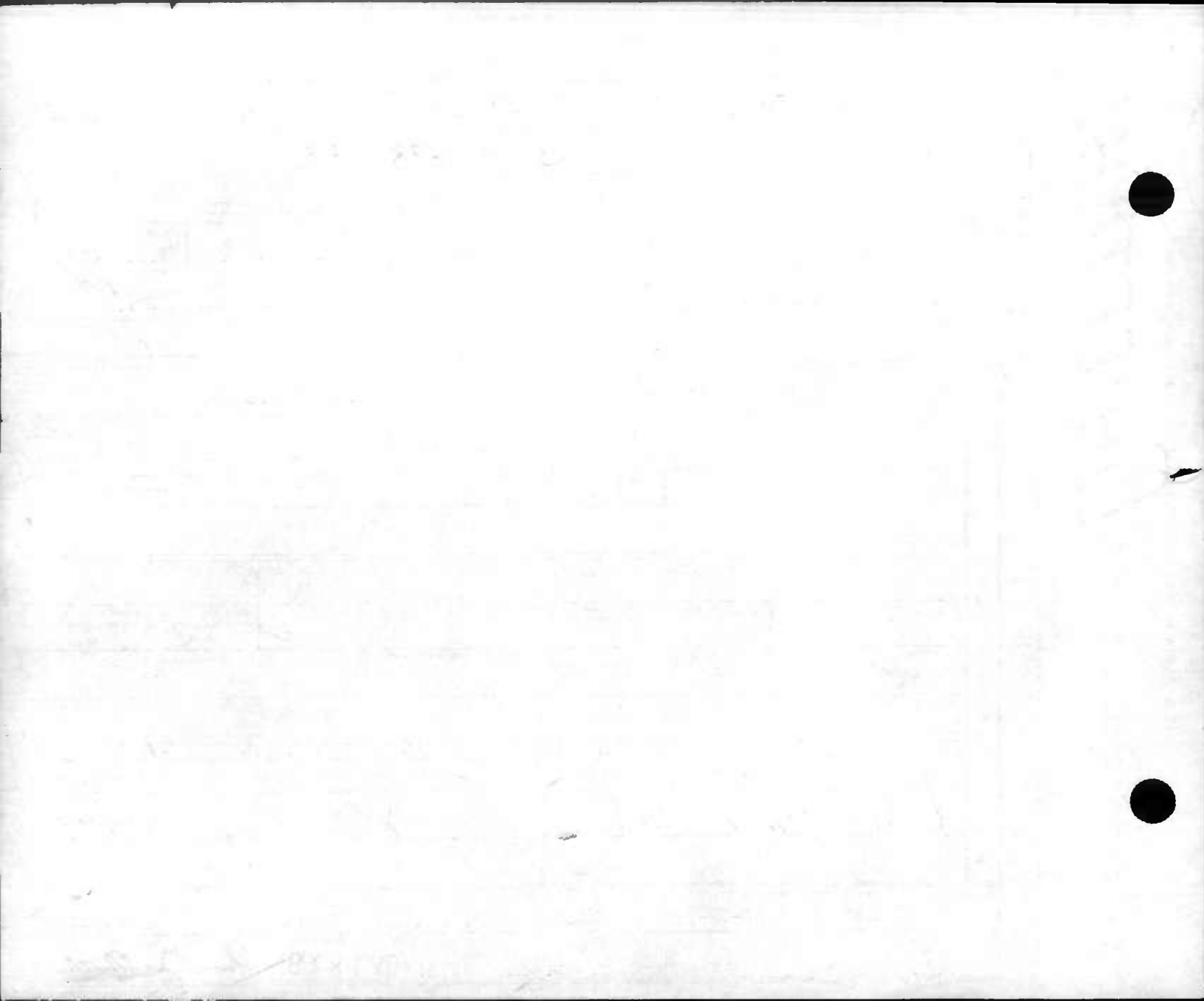
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  | REG. NO.        |   |
|--|--|--|--|--|-----------------|---|
| 1. FOR STATE REGISTRAR   |  |  | 2a. DATE OF DEATH  |  | 2b. HOUR        |   |
| I DECEASED NAME (TYPE OR PRINT) <b>VICTOR M LENZER</b>   |  |  | MONTH DAY YEAR <b>11 16 81</b>   |  | 1635 M          |   |
| 3 SEX <b>M</b>   | 4 RACE <b>W</b>  | 5. DATE OF BIRTH   | 8 AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR |   |
|  |  | MONTH DAY YEAR <b>3 10 1898</b>  | <b>83</b> YRS  |  | IF UNDER 24 HRS |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Alabama</b>   | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.                                  |  |                 |   |
| 10 CITY OR TOWN OF DEATH <b>Annapolis</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel Gen. Hospital</b> | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Spec. Officer</b>   | 12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't</b>  |  |                 |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  |                 |   |
| 13a. STATE <b>Md.</b>  | 13b. COUNTY <b>A.A. Co.</b>  | 13c. CITY OR TOWN <b>Annapolis</b>   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS <b>8 46 Monroe St. Apt T7</b>  |                 |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>George Lenzer</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Cora Biehle</b>  |  |  |                 |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <b>Yes</b>   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1918 058-32-4626</b>   |  | 17 INFORMANT ADDRESS <b>Louis Dunn Same as 13e</b>   |                 |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>acute infarct m.2.</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>70 hrs -</b> |  |  |  |  |                 |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0  |  |  |  |  |                 |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                 |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |                 |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 11/16</b> , 19 <b>79</b> , to <b>11/16</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>11/16</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |  |                 |   |
| 22b. SIGNATURE <b>Robert Hulse M.D.</b>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                 | 22c. DATE SIGNED <b>11/16/81</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |                 |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>   |  | 23b. DATE <b>11-17-81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Westview Mem. Park</b>   |                 | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>   |
| 24. FUNERAL DIRECTOR NAME <b>T.A. Hardesty</b>   |  | ADDRESS <b>Annapolis Maryland 21401</b>  |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 18 1981</b>   |                 | 25b. REGISTRAR'S SIGNATURE <b>Anna J. Hardesty</b>  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 9 3 1

REG. NO.

|   |  |   |  |   |  |  |  |   |  |
|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>RICHARD CLARK LEWIS</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11 08 81</b>   |  |  |  | 2b. HOUR<br><b>12 38 P.M.</b>   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>04 05 02</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD</b>                            |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>ANNAPOLIS</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ANNE ARUNDEL GENERAL HOSP.</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SUPERINTENDANT CONSTRUC.</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |  |  |   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>ANNE ARUNDEL</b>  |  | 13c. CITY OR TOWN<br><b>ANNAPOLIS</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>     |  | 13e. STREET ADDRESS<br><b>130 HEARNE RD. APT. 1014</b>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>JEREMIAH LEWIS</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>MELINDA BURDETT</b>  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>212124025</b>  |  | 17. INFORMANT ADDRESS<br><b>LAURA LEWIS 130 HEARNE RD. APT. 1014</b>                             |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARRHYTHMIA</b><br><b>4280</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CONGESTIVE HEART FAILURE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.<br><b>none</b>   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |   |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>MAY 19 81</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>MAY 19 81</b> to <b>November 8 81</b> , that (I) (we) lost <b>saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.</b>  |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Thomas M. Walsh MD</b>   |  |   |  | DEGREE<br><b>MD</b>   |  |  |  | 22c. DATE SIGNED<br><b>11-08-81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>THOMAS M. WALSH M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>ANNE ARUNDEL GEN. HOSPITAL</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>11/11/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARDENS OF FAITH</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTO. BALTO. MD</b>                               |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Jody Cook</b>   |  |   |  | ADDRESS<br><b>1211 Chesapeake Ave.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 10 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                  |  |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

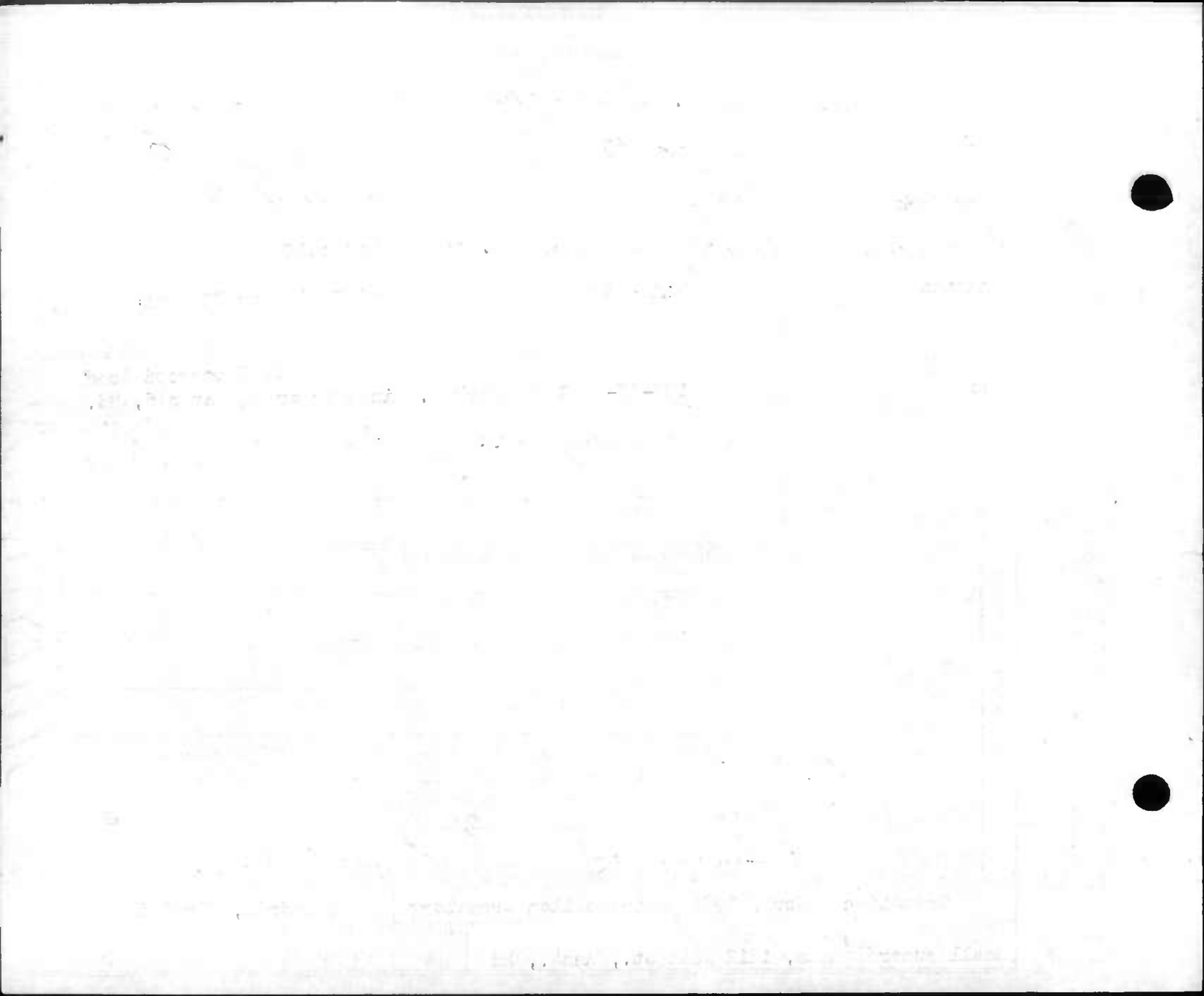
BP

DHM-17  
(VR A15 ME 5)  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |                                       |   |   |
|--|---------------------------------------|---|---|
| 1. FOR STATE REGISTRAR   |                                       | 27932   |   |
| 1. DECEASED NAME (TYPE OR PRINT)   |                                       | 2a. DATE KNOWN OF DEATH                                       |   |
| FIRST MIDDLE LAST<br>Katherine M. Linenberger  |                                       | ESTIMATED MONTH DAY YEAR<br>11 4 1981                         |   |
| 3. SEX   | 4. RACE                               | 5. DATE OF BIRTH  | 6. AGE (IN YEARS)                           |
| F  | W                                     | MONTH DAY YEAR<br>3 21 18 63                                  | LAST BIRTHDAY MONTHS DAYS HOURS MIN<br>YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |                                       | 7b. CITIZEN OF WHAT COUNTRY?                                  |   |
| New York   |                                       | USA   |   |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>   |                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |   |
| 10. CITY OR TOWN OF DEATH  |                                       | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |   |
| Annapolis  |                                       | housewife   |   |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |                                       | 12b. KIND OF BUSINESS OR INDUSTRY                             |   |
| Rauscy-Dr-Edgewater  |                                       |   |   |
| 13a. STATE   |                                       | 13b. CITY OR TOWN   |   |
| Montana  |                                       | Whitefish   |   |
| 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                       | 13d. STREET ADDRESS   |   |
|  |                                       | 6300 Highway 93 South   |   |
| 14. FATHER'S NAME  |                                       | 15. MOTHER'S MAIDEN NAME                                      |   |
| FIRST MIDDLE LAST<br>Charles Mahony  | FIRST MIDDLE LAST<br>Margaret Mahoney |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |                                       | 16b. SOCIAL SECURITY NO.                                      |   |
| no   |                                       | 130-05-1540   |   |
| 17. INFORMANT  |                                       | ADDRESS   |   |
| Mark E. Linengerger  |                                       | 1247 Dogwood Road Arnold, Md.                                 |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |                                       |   |   |
| PART I DEATH WAS CAUSED BY:  |                                       |   |   |
| IMMEDIATE CAUSE (a) Coronary Artery Disease  |                                       |   |   |
| DUE TO, OR AS A CONSEQUENCE OF   |                                       |   |   |
| (b) 4149   |                                       |   |   |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last   |                                       |   |   |
| (c)  |                                       |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                                       |   |   |
| 19a. DATE OF OPERATION   |                                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?             |   |
|  |                                       |   |   |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                       |   |   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                                       | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19       |   |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                                       |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |                                       | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |   |
| 21f. LOCATION STREET   |                                       | CITY OR TOWN COUNTY STATE                                     |   |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                       |   |   |
| ACTUAL SIGNATURE   |                                       | TITLE (SPECIFY)   |   |
| E. Linenberger   |                                       | M.D. Deputis  |   |
| EXAMINER'S NAME (TYPE OR PRINT)  |                                       | ADDRESS   |   |
| E. Linenberger   |                                       | Annapolis, Md.  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |                                       | 23b. DATE   |   |
| Cremation  |                                       | Nov 7 1981  |   |
| 23c. NAME OF CEMETERY OR CREMATORY   |                                       | 23d. LOCATION CITY OR TOWN COUNTY STATE                       |   |
| Metropolitan Crematory   |                                       | Alexandria, Virginia  |   |
| 24. FUNERAL DIRECTOR NAME  |                                       | 25a. DATE REC'D BY REGISTRAR                                  |   |
| Beall Funeral Home, 1212 West St., Anna., Md   |                                       | Nov 12 1981   |   |
| 25b. REGISTRAR'S SIGNATURE   |                                       |   |   |
| Frances Van Natten   |                                       |   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

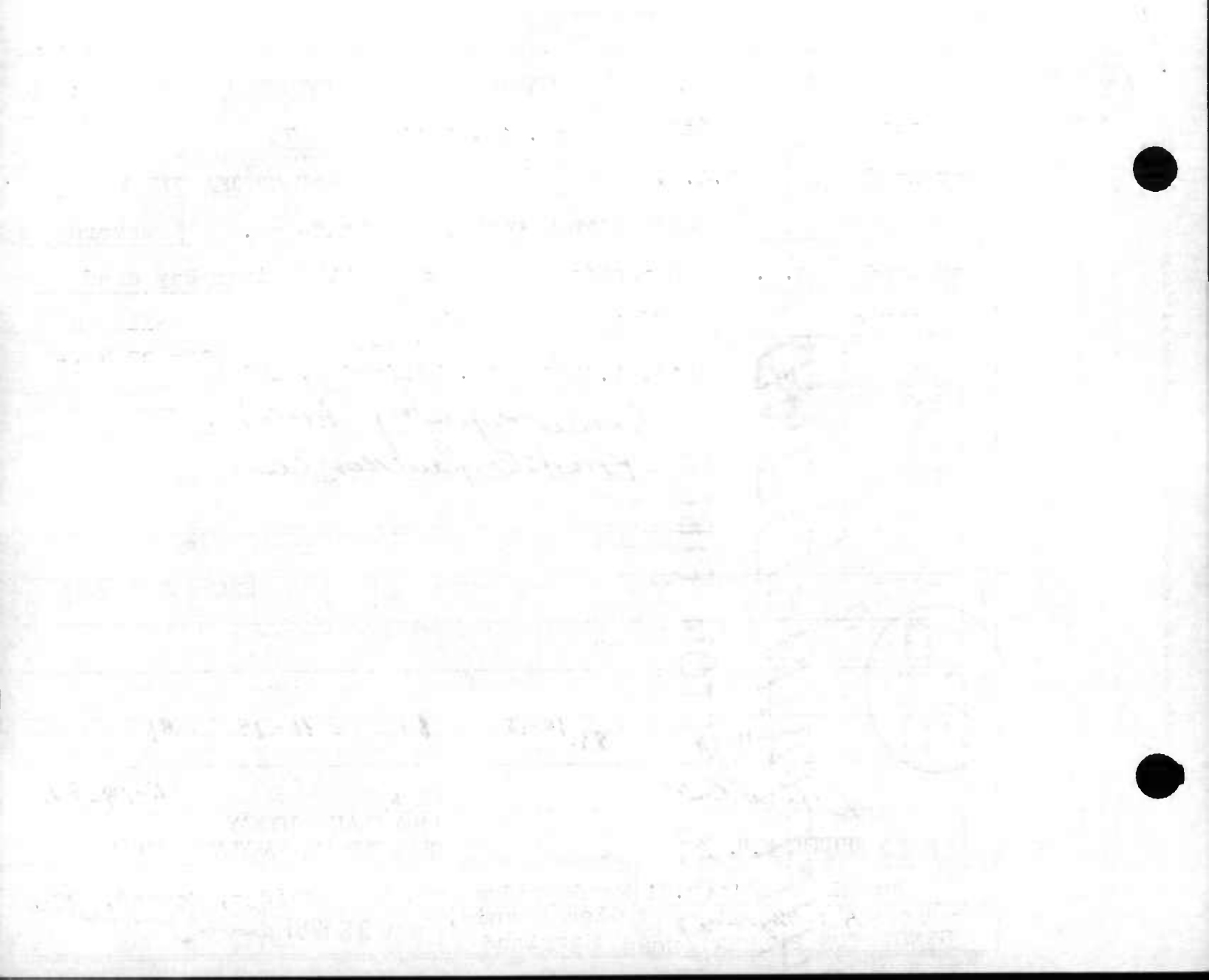
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |   |  |  |  |   |                                     | 81 27933   | REG. NO. | E.S.T. |
|--|--|---|---|---|--|--|--|---|-------------------------------------|--|----------|--------|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>FRANK Joseph LUDWIG</b>  |  |   |   |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOVEMBER 19, 1981</b>   |  |   | 2b. HOUR<br><b>12:55AM</b>          |  |          |        |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Jan. 11, 1911</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |                                     |  |          |        |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD.</b>   |  |   |                                     |  |          |        |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Self-Emp.</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Tavern</b>  |                                     |  |          |        |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>A.A.</b>  |   | 13c. CITY OR TOWN<br><b>Annapolis</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>1105 River Bay Road</b>   |                                     |  |          |        |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>George Ludwig</b>  |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Maude Callahan</b>   |  |  |  |   |                                     |  |          |        |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>N/A</b>  |   | 17. INFORMANT (Wife) ADDRESS<br><b>Mrs. Mildred M. Ludwig Same as # 13</b>  |  |  |  |   |                                     |  |          |        |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>- Cardiorespiratory Arrest.</b><br><b>1579</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>- Metastatic Pancreas Ca.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |   |   |  |  |  |   |                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH     |          |        |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.  |  |   |   |   |  |  |  |   |                                     |  |          |        |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                     |  |          |        |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |                                     |  |          |        |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |                                     |  |          |        |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-15</b> , 19 <b>81</b> , to <b>11-19</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>11-19</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                  |  |   |   |   |  |  |  |   |                                     |  |          |        |
| 22b. SIGNATURE <b>R. H. Reider</b> DEGREE  |  |   |   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED<br><b>11-19-81</b> |  |          |        |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RUBEN REIDER, M.D.</b>   |  |   |   |   |  | 22e. ADDRESS<br><b>1406 CRAIN HIGHWAY<br/>GLEN BURNIE, MARYLAND 21061</b>  |  |   |                                     |  |          |        |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>23 Nov. 81</b>                                      |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Mem. Pk</b> |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Elkridge, Howard, MD.</b>   |                                     |  |          |        |
| 24. FUNERAL DIRECTOR NAME<br><b>R. H. Hopkins</b>  |  |   |   |   |  | ADDRESS<br><b>Glen Burnie, Maryland</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 23 1981</b>   |                                     | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i> |          |        |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  | REG. NO. 81 27934  |  |
|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |   |  |  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Harold Delmer Malkie</b>  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>11 18 81</b>                                  |  | 2b. HOUR <b>8:10 AM</b>  |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>11 18 98</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY) <b>N.Y.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL Co</b> MD                    |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>ANNAPOLIS</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ANNE ARUNDEL General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret.</b>      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Civil Service</b>  |  |  |  |
| 13a. STATE<br><b>MD</b>  |  |   |  |   |  | 13b. COUNTY<br><b>A.A.</b>   |  | 13c. CITY OR TOWN<br><b>Annapolis</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frederick Malkie</b>  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Maude Lamphier</b>               |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b> (IF YES, GIVE WAR OR DATES)<br><b>WWI</b>  |  |   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>578-05-2114</b>                                       |  | 17. INFORMANT<br><b>Agnes M. Malkie</b>  |  | ADDRESS<br><b>Same as #13</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>1519</b> IMMEDIATE CAUSE (a) <b>Stomach Cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 yr</b> |  |   |  |   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>2/5 81</b><br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>2/5 81</b><br><b>8/18 81</b> |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/17 81</b> to <b>8/18 81</b> , that (I) (we) lost <b>8/17 81</b> above (I) (we) (did) not view the body after death.  |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Enser W. Cole III</b>   |  |   |  |   |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/18/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ENSER W. COLE III</b>  |  |   |  |   |  | 22e. ADDRESS<br><b>121 CATHEDRAL ST ANNAPOLIS MD</b>                                 |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |  |   |  | 23b. DATE<br><b>Nov. 20, 1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Cemetery</b>                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Annapolis A.A. MD</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Taylor Funeral Chapel, Annapolis MD</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 19 1981</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Jan Keith</b>   |  |  |  |

MEDICAL CERTIFICATION

6. 2. 15

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11

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Lower section of handwritten text, continuing the list or series of entries. The text is mirrored across the page, suggesting bleed-through from the reverse side.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 9 3 5

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>John A. Marsh</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 13 81</b>                                    |  | 2b. HOUR<br><b>11:45AM</b>   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Caucasian</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7- 1- 1918</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Missouri</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel</b> MD.                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Crofton</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1704 Fallsway Dr.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Budget Analyst</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Fed. Govt.</b>                               |
| 13a. STATE<br><b>Md.</b>   |   |   | 13b. COUNTY<br><b>Anne Arundel</b>  | 13c. CITY OR TOWN<br><b>Crofton</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George A. Marsh</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lena Hapes</b>                        |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>1941-1945</b>   | 17. INFORMANT<br>ADDRESS<br><b>Juanita W. Marsh Same as # 13</b>                          |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Edema - Cardiopulmonary Arrest</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>metastatic Carcinoma from Lung.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>None</b>   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>None</b>   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1978</b> , 19 <b>78</b> , to <b>Nov 13</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>11/12/81</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.   |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Ronald C. Sroka</b>   |   | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>11/14/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Ronald C. Sroka, M.D.</b>  |   | 22e. ADDRESS<br><b>3 Village Green Crofton, Md. 21114</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>11-17-81</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill</b>                        |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Suitland Pr. Geo. Md.</b>   |   |   |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Beall Funeral Home</b>  |   | ADDRESS<br><b>16,000 Annapolis Rd. Bowie, Md.</b>   |   | 25. DATE REC'D. BY REGISTRAR<br><b>NOV 18 1981</b>                             |  |
|  |   | 25. REGISTRAR'S SIGNATURE<br><b>James J. Nathan</b>   |   |  |  |

BP



Item 8 G 562 12/7/81 GAB

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
1. STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |                            |   |
|---|--|---|--|---|----------------------------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MUSIC Martin</b> |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-19-81</b> |   | 2b. HOUR<br><b>5:55 AM</b> |   |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1 23 20</b>  |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b><br>YRS.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Georgia</b>                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL</b> MD.                                 |
| 10. CITY OR TOWN OF DEATH<br><b>Annapolis</b>                                   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ANNE ARUNDEL General Hosp</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>House wife</b>   |                            | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>A.A.</b>  |  | 13c. CITY OR TOWN<br><b>Artold</b>  |                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John MOORE</b>                     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>GLAVAN FLINT</b>  |  | 16. STREET ADDRESS<br><b>814 BARRETT AVE</b>  |                            |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)            |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>ADDRESS<br><b>BEVERLY MARTIN 814 BARRETT AVE.</b>  |                            |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

4275

IMMEDIATE CAUSE (a) **Cardiac arrest**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) **ventricular arrhythmia**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Howard D. Goldstein</b>  |  |  |  | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Howard D. Goldstein</b>   |  |  |  | 22e. ADDRESS   |  |  |  |

|  |  |                              |  |  |  |   |  |
|--|--|------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>11/24/81</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>                           |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>E.L. Phillips</b>       |  |                              |  | ADDRESS<br><b>1721 N. Monroe St.</b>                 |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>NOV 24 1981 Frances San Martin</b> |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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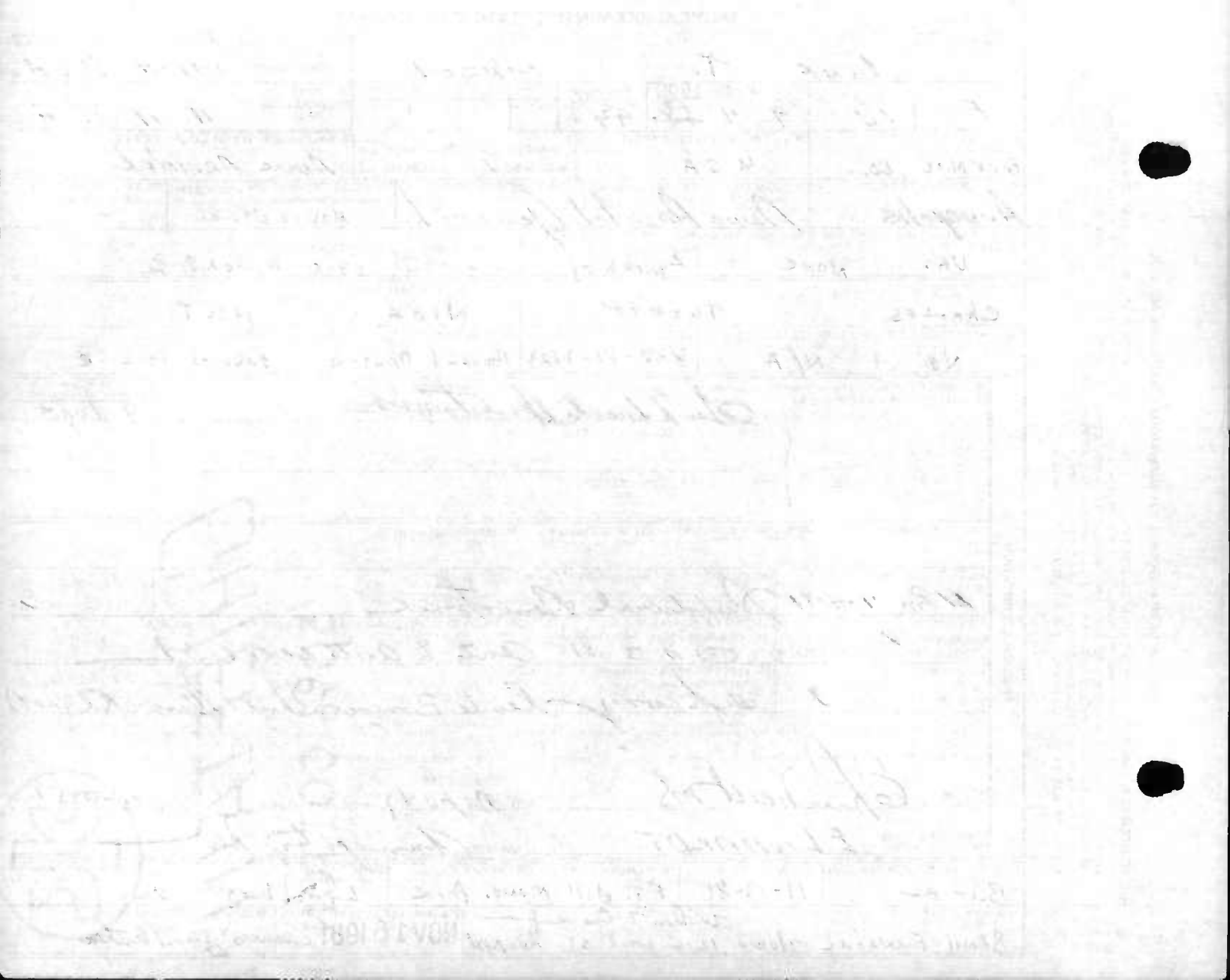
Items #386 Film G562 12/15/81 re  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

27937

|   |              |  |  |   |  |   |  |  |  |   |  |   |  |
|---|--------------|--|--|---|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |              | FIRST<br>LONA T.   |  | MIDDLE<br>T.  |  | LAST<br>MASON   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 11-11 1981     |  |   |  | 2b. HOUR<br>A M   |  |
| 3. SEX<br>F   | 4. RACE<br>W | 5. DATE OF BIRTH<br>MONTH DAY YEAR 9 4 58  |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) 23 YRS.  |  | IF UNDER 1 YR.<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR 11 11 1981 |  | 2d. HOUR<br>A M   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Brookfield, Va.  |              | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel MD   |  |  |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Annapolis  |              | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Anne Arundel General |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>-   |  |   |  |   |  |
| 13a. STATE<br>VA.   |              | 13b. COUNTY<br>None  |  | 13c. CITY OR TOWN<br>Lynchburg  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>5810 Apache Tr.   |  |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Tucker  |              |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>NIDA HOLT  |  |   |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |              | (IF YES, GIVE WAR OR DATES)<br>N/A   |  | 16b. SOCIAL SECURITY NO.<br>888-19-3423   |  | 17. INFORMANT<br>Howard Dawson  |  | ADDRESS<br>Same as 13a - e   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Subdural Hematoma<br>DUE TO, OR AS A CONSEQUENCE OF<br>8129<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |              |  |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>9 days                              |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |              |  |  |   |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br>8 PM 11-4-81  |              |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br>Subdural Hematoma  |  |   |  |  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |              |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 11 3 1981   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Auto to Auto Accident |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK  |              |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>Highway  |  |   |  | 21f. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Route 2 near Church Lane, R.R. MD                        |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |              |  |  |   |  |   |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE<br>E. Livhardt MD  |              |  |  | TITLE (SPECIFY)<br>M.D. Deputy  |  |   |  | MEDICAL EXAMINER<br>DATE SIGNED 11-4-81  |  |   |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) E. LIVHARDT  |              |  |  | ADDRESS<br>Annapolis, Md  |  |   |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |              | 23b. DATE<br>11-13-81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Ft. Hill Memo. Park   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Lynchburg Va.  |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>BRALL FUNERAL HOME, 1212 WEST ST. ANNAPOLIS   |              |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 16 1981  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>Giancarlo Jean Vantreese   |  |   |  |   |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 1 2 7 9 3 8

|   |  |  |  |   |                       |  |
|---|--|--|--|---|-----------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>ADDIE PADGETT McCLELLAN   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 27, 1981 |   | 2b. HOUR<br>7:55 A.M. |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>DEC. 9, 1888  |                       |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>92 YRS.  |  | 7. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                  |  | 8. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel Co. MD.  |                       |  |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>TENN.   |  | 10. CITY OR TOWN OF DEATH<br>Annapolis                                 |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Annapolis Conv. Nurs. Home |                       |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FORMERLY OR WORKING LIFE)<br>Legal Steno.  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Attorney                          |  |   |                       |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>A.A. Co.  |  | 13c. CITY OR TOWN<br>Glen Burnie  |                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Sidney Padgett  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Frances Malone   |  | 16. ADDRESS<br>Same as # 13   |                       |  |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>N/A   |  | 17b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A         |  | 17c. INFORMANT<br>Mr. William D. McClellan (son)  |                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cerebral embolus</u><br>4/49<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Cardiac arrhythmia</u><br>(c) <u>Coronary heart disease</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u><br><u>3 days</u><br><u>unk.</u> |  |  |  |   |                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).   |  |  |  |   |                       |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |                       |  |
| 22b. SIGNATURE<br>Charles W. Kinzer MD<br>DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |  |  | 22c. DATE SIGNED<br>Nov 27, 1981  |                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CHARLES W. KINZER MD   |  |  |  | 22e. ADDRESS<br>ANNAPOLIS, MD.  |                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>DEC '81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Lukes Episc. Ch. Cem. Marianna Fla.   |                       |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SINGLETON FUNERAL HOME, GLEN BURNIE, MD.  |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 1 1981                            |  | 25b. REGISTRAR'S SIGNATURE<br>Charles W. Kinzer   |                       |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  | REG. NO. 81 27939   |  |
|---|--|--|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   |  |  |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Fannie R. McDonald</b>   |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11 9 81</b>   |  | 2b. HOUR<br><b>10:50 AM</b>  |  |   |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>06 12 84</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>97</b>  |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br><b>00 00 00</b>  |  | 8. IF UNDER 24 HRS. HOURS MIN.<br><b>00 00</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>Balt., Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL Co MD</b>                            |  |  |  |   |  |
| 11. CITY OR TOWN OF DEATH<br><b>ANNAPOLIS</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ANNE ARUNDEL GENERAL Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>A.A. Co.</b>   |  | 13c. CITY OR TOWN<br><b>Annapolis</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>13 Southgate Ave.</b>  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Amos Reeder</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Unknown Bristow</b>  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO. (U.S. GIVE WAR OR DATES)<br><b>n/a</b>  |  | 17. INFORMANT<br><b>Donald Mc Donald</b>  |  | ADDRESS<br><b>4531 S. Pollinghouse Rd. Harwood, Md.</b>                                      |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hyperkalemia due to</b><br><b>4409</b><br>DUE TO, OR AS CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Acute Renal Failure due to</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diffuse Atherosclerosis</b> |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)               |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 9, 1975</b> to <b>9 Nov 1981</b> , that (I) (we) last saw the deceased alive on <b>9 Nov 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Jon B. Lowe, M.D.</b>  |  |  |  |   |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>9 Nov 81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jon B. Lowe, M.D.</b>   |  |  |  |   |  | 22e. ADDRESS<br><b>121 Cathedral St., Annap., Md.</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  |  | 23b. DATE<br><b>11-11-81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b>                                 |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Brooklyn Park, Md.</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Beall Funeral Home, 1212 West St., Annap., Md.</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 12 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Francis J. Nathan</b>   |  |   |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 9 4 0

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |   |   |
|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>IDA Elizabeth McQuighan             |   | 2a. DATE OF DEATH<br>(NOV) 11 26 81   |   | 2b. HOUR<br>3:48 M  |
| 3. SEX<br>Female   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>June 7, 1894  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York                      | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel Co. MD.                                    |
| 10. CITY OR TOWN OF DEATH<br>Millersville                                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Knottwood Manor N.H. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home   |
| 13a. STATE<br>Maryland   |   | 13b. COUNTY<br>A.A. Co.   | 13c. CITY OR TOWN<br>Glen Burnie  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST George MIDDLE LAST White                        |   | 15. MOTHER'S MAIDEN NAME<br>FIRST Ida MIDDLE LAST Burns   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>N/A  |   | 17. INFORMANT<br>ADDRESS Odenton, Md.<br>Mr. Joseph McQuighan (son)                             |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a)

CONGESTIVE HEART FAILURE

4292  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) ATHEROSCLEROTIC CARDIO-VASCULAR D.

DUE TO, OR AS A CONSEQUENCE OF

(c)

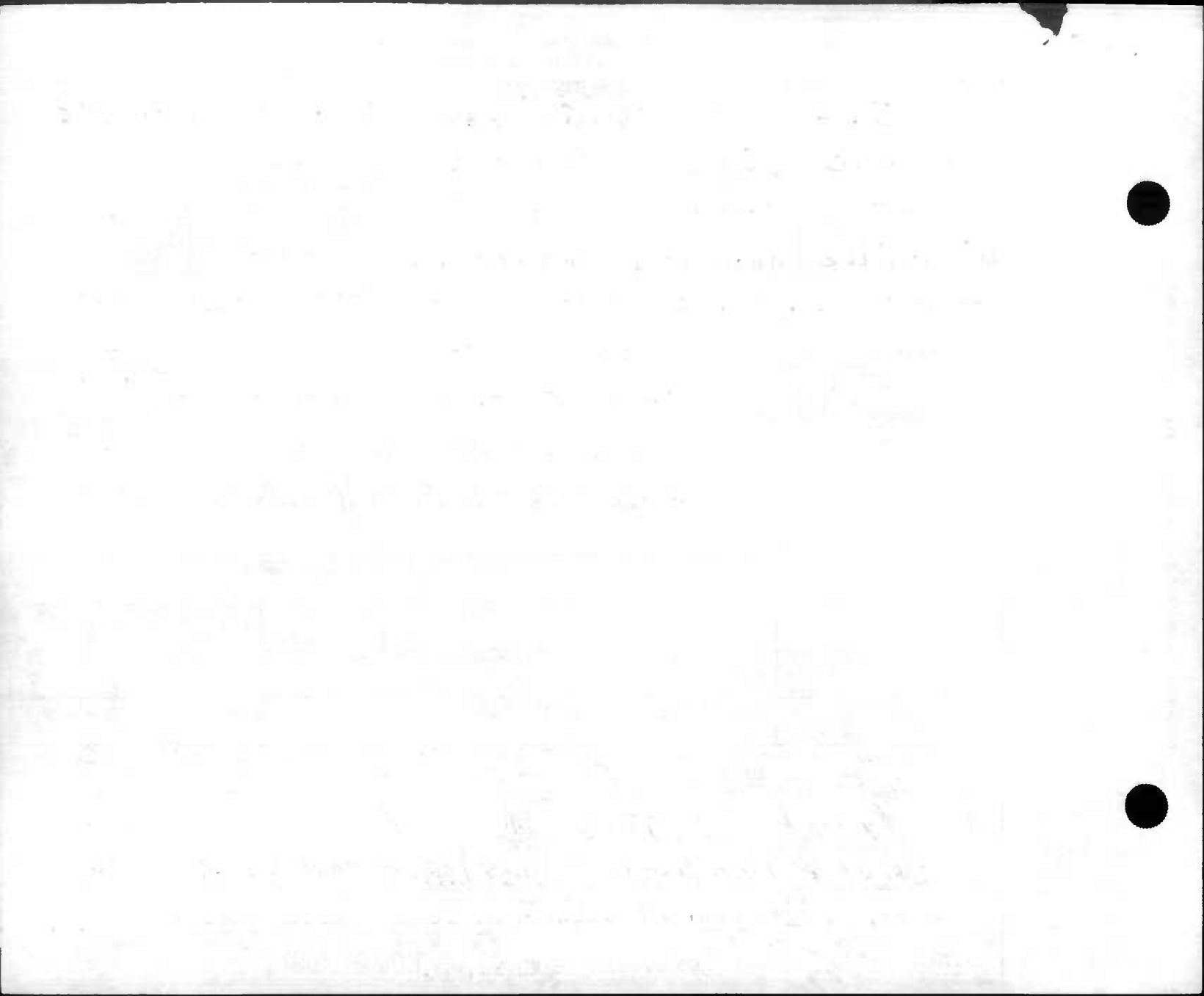
YEARS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

|   |  |  |   |
|---|--|--|---|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (1) (this hospital) attended the deceased from SEPT 28, 1981, to NOV. 26, 1981, that (1) (we) lost<br>saw the deceased alive on 11/17, 1981, and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above (1) (we) did not view the body after death. |  |  |   |
| 22b. SIGNATURE<br>Barry R. Nathanson  | DEGREE<br>MD   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br>11/26/81  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BARRY R. NATHANSON   | 22e. ADDRESS<br>1438 DEFENSE HWY CAMBRIDGE, MD.                        |  |   |

|   |                         |   |  |
|---|-------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                        | 23b. DATE<br>30 NOV '81 | 23c. NAME OF CEMETERY OR CREMATORY<br>Moravian Cemetery | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Staten Island N.Y. |
| 24. FUNERAL DIRECTOR<br>J. Easton<br>SINGLETON FUNERAL HOME, GLEN BURNIE, MD. |                         | 25a. DATE REC'D. BY REGISTRAR<br>NOV 27 1981            | 25b. REGISTRAR'S SIGNATURE<br>Barry R. Nathanson                 |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 9 4 1

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |                |   |  |
|---|--|--|--|---|----------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST <i>Ruth</i> MIDDLE <i>Alma</i> LAST <i>Meyer</i> |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>Nov. 12, 1981</i> |   | 2b. HOUR<br>AM |   |  |
| 3. SEX<br><i>female</i>   |  | 4. RACE<br><i>white</i>  |  | 5. DATE OF BIRTH<br><i>Aug. 24, 1893</i> YEAR   |                | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>88</i> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Wash. D.C.</i>                                |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Anne Arundel Co.</i> MD.                             |  |
| 10. CITY OR TOWN OF DEATH<br><i>Annapolis</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Annapolis Nursing Home</i> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>gov't</i>  |                | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>war dept.</i>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |                |   |  |
| 13a. STATE<br><i>Md.</i>  |  | 13b. COUNTY<br><i>A.A. Co.</i>   |  | 13c. CITY OR TOWN<br><i>Edgewater</i>   |                | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST <i>Edward</i> MIDDLE LAST <i>Meyer</i>                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <i>Mary</i> MIDDLE LAST <i>Getling</i>   |  |   |                |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>no</i>             |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>578-32-8605</i>  |  | 17. INFORMANT<br>ADDRESS<br><i>Mrs. Ruth Pixton 324 Riverside Rd. Edgewater</i>   |                |   |  |

|  |  |  |  |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cerebral anoxia</i> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><i>Immediate</i>    |  |
| 4409<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a), stating the<br>underlying cause last.  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Cardiac failure</i><br>months |  |
|  |  | DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>arteriosclerosis</i><br>years |  |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  
*arthritis -*

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><i>William H. Choate, MD</i>   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |   |  |

|   |  |                              |  |   |  |   |  |
|---|--|------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>cremation</i>                      |  | 23b. DATE<br><i>11/13/81</i> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Westview Crematory</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore, Md.</i> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Hardesty Funeral Home 12 Ridgely Ave. Ann. Md.</i> |  |                              |  | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 13 1981</i>             |  | 25b. REGISTRAR'S SIGNATURE<br><i>Thomas J. North</i>                |  |

Stammzahl 16121 vom

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 9 4 2

1. FOR  
STATE  
REGISTRAR

REG. NO.

EST

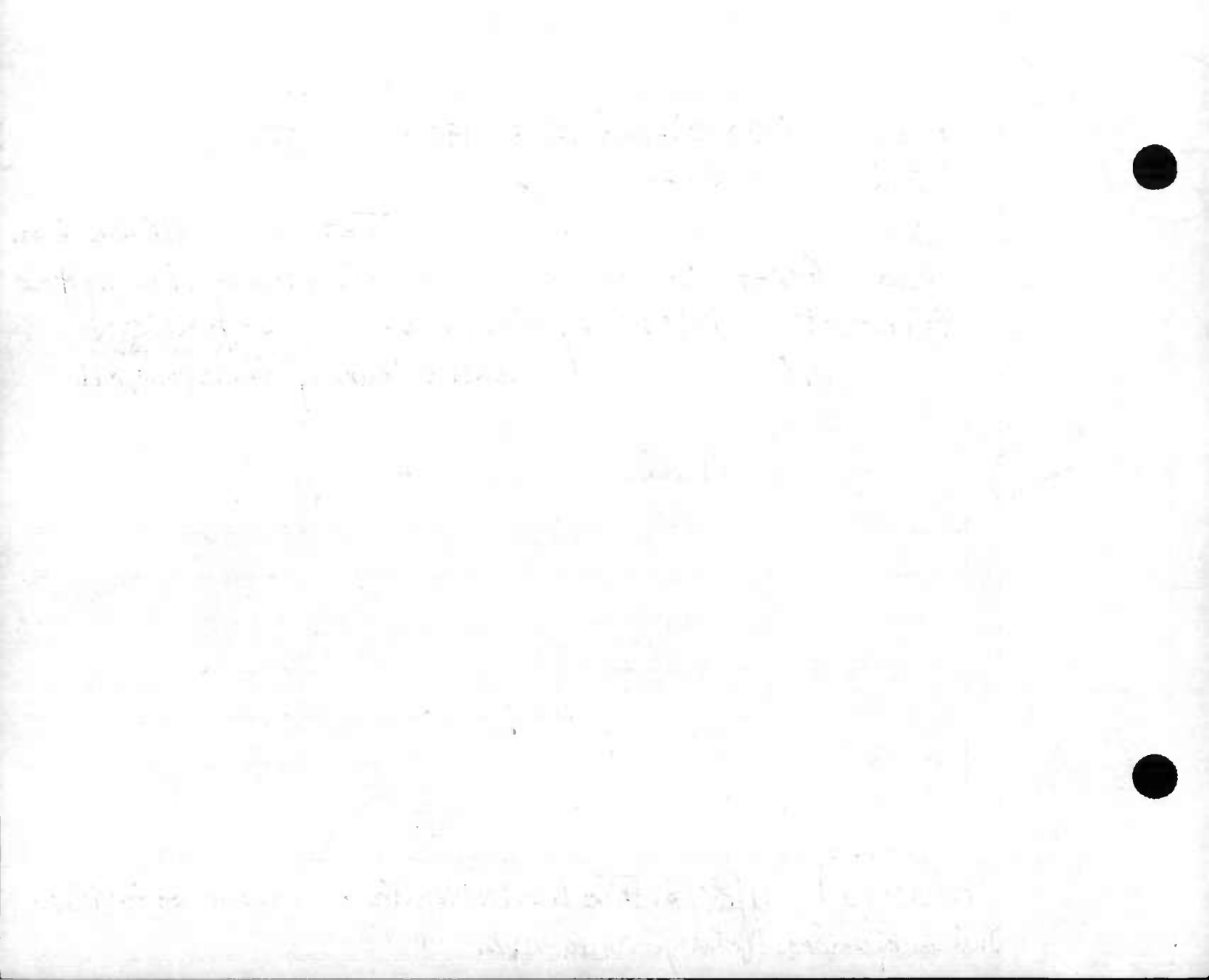
|   |  |  |   |   |                            |  |  |
|---|--|--|---|---|----------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>CHARLES HENRY MOBRAY, SR.</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 24, 1981</b> |   | 2b. HOUR<br><b>11:00 P</b> |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Colored Amer.</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 8 1909</b>   |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS MONTHS DAYS<br><b>72</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(GIVE WORK FOR MOST OF WORKING LIFE)<br><b>Ret.</b>  |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Naval Acad.</b>   |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>A.A.</b>   |   | 13c. CITY OR TOWN<br><b>Glen Burnie</b>   |                            | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Albert Mobray</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Susanna Johnson</b>  |   | 16. STREET ADDRESS<br><b>Plaza Manor Nursing Home</b>   |                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>NO</b>  |   | 17. INFORMANT<br><b>MANNIE MURRAY-ANNAPOLIS, MD.</b>  |                            |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>aldy, supris. CVA</b><br><b>5/40</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Pulmonary Edema, Hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ |  |  |   |   |                            |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |   |   |                            |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                            |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/24 1981</b> to <b>11/24 1981</b> , that (I) (we) last saw the deceased alive on <b>11/24 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.   |  |  |   |   |                            |  |  |
| 22b. SIGNATURE<br><b>H. Tawhidian MD</b>  |  |  |   | DEGREE<br><b>MD</b>   |                            | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HAMID A. TOWHIDIAN, MD.</b>   |  |  |   | 22e. ADDRESS<br><b>2334 Mountain Road<br/>Pasadena, Maryland 21122</b>  |                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY  |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |
| <b>Burial</b>   |  | <b>11/30/81</b>  |   | <b>Pine Lawn Mem. Park</b>  |                            | <b>Annapolis, Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>William Green &amp; Sons Mortuary - Annapolis, Md.</b>   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 27 1981</b>   |                            |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |  |
|---|--|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO. 8 1 2 7 9 4 3  |  |   |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Cedric M Moody</b>   |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>November 14 1981</b>                                  |  | 2b. HOUR<br><b>9 20</b> M.  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>CAU</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Sep 26 1912</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>69</b>  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel</b> MD.                              |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Annapolis</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Anne Arundel General</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ship Master</b>          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Merchant Marine</b>   |  |
| 13a. STATE<br><b>MARYland</b>   |  | 13b. COUNTY<br><b>Anne Arundel</b>  |  | 13c. CITY OR TOWN<br><b>Severna Park</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>728 OAK GROVE Circle</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Charles M. Moody</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Gladys Kuhn</b>  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Unkn.</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>212 09 7849</b>  |  | 17. INFORMANT ADDRESS<br><b>Hosp/pc Chant</b>  |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4960 Rt sided heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic obstructive lung disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>10 years</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>18 mo</b> |  |   |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>arteriosclerotic Cardiovascular disease with history of two infarction</b>   |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>MAY</b> 19 <b>69</b> , to <b>Nov 14</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>Nov 14 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.               |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Donald Hecky</b> (For Thomas Gellis)   |  |   |  | 22c. DATE SIGNED<br><b>11/17/81</b>   |  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Donald Hecky</b>  |  |   |  | 22e. ADDRESS<br><b>10100 HISPMD.</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b>   |  | 23b. DATE<br><b>11/14/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Anatomy Board</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 20 1981</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anne Gellis</b>   |  |   |  |



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
1 - STATE  
REGISTRAR

REG. NO.

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|  |  |  |   |   |                                   |  |  |
|--|--|--|---|---|-----------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JOSEPHINE ALTHEA MUELLER</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 12, 1981</b> |   | 2b. HOUR<br>MIN.<br><b>5:20 P</b> |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 14, 1924</b>   |                                   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>57</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |                                   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>AA Co</b>  |   | 13c. CITY OR TOWN<br><b>Glen Burnie</b>   |                                   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 13e. STREET ADDRESS<br><b>208 PLYMOUTH LANE (apt. D)</b>   |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Walter Wright</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emma Warner</b>   |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br><b>N/A</b>   |   | 17. INFORMANT (Husband) ADDRESS<br><b>Same As # 13</b>  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory and Hepatic Failure</b><br><b>5715</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Cirrhosis of the Liver</b><br>(c) <b>Ruptured Stomach</b> |  |  |   |   |                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |   |                                   |  |  |
| 19a. DATE OF OPERATION<br><b>Sept. 19, 1981</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Ruptured Stomach</b>  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sept. 19</b> 19 <b>81</b> to <b>Nov. 12</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>Nov. 12</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                           |  |  |   |   |                                   |  |  |
| 22b. SIGNATURE<br><b>D. C. Bae, M.D.</b>   |  | 22c. ADDRESS<br><b>2334 Mountain Road<br/>Pasadena, Maryland 21122</b>   |   | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HO JIN BAE, M.D.</b>  |                                   | 22e. DATE SIGNED<br><b>11/13/81</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>14 Nov. 81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Pk.</b>  |                                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie, A.A., MD.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Singleton Funeral Home</b>  |  | ADDRESS<br><b>Glen Burnie, MD.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 17 1981</b>   |                                   | 25b. REGISTRAR'S SIGNATURE<br><b>James J. [Signature]</b>  |  |

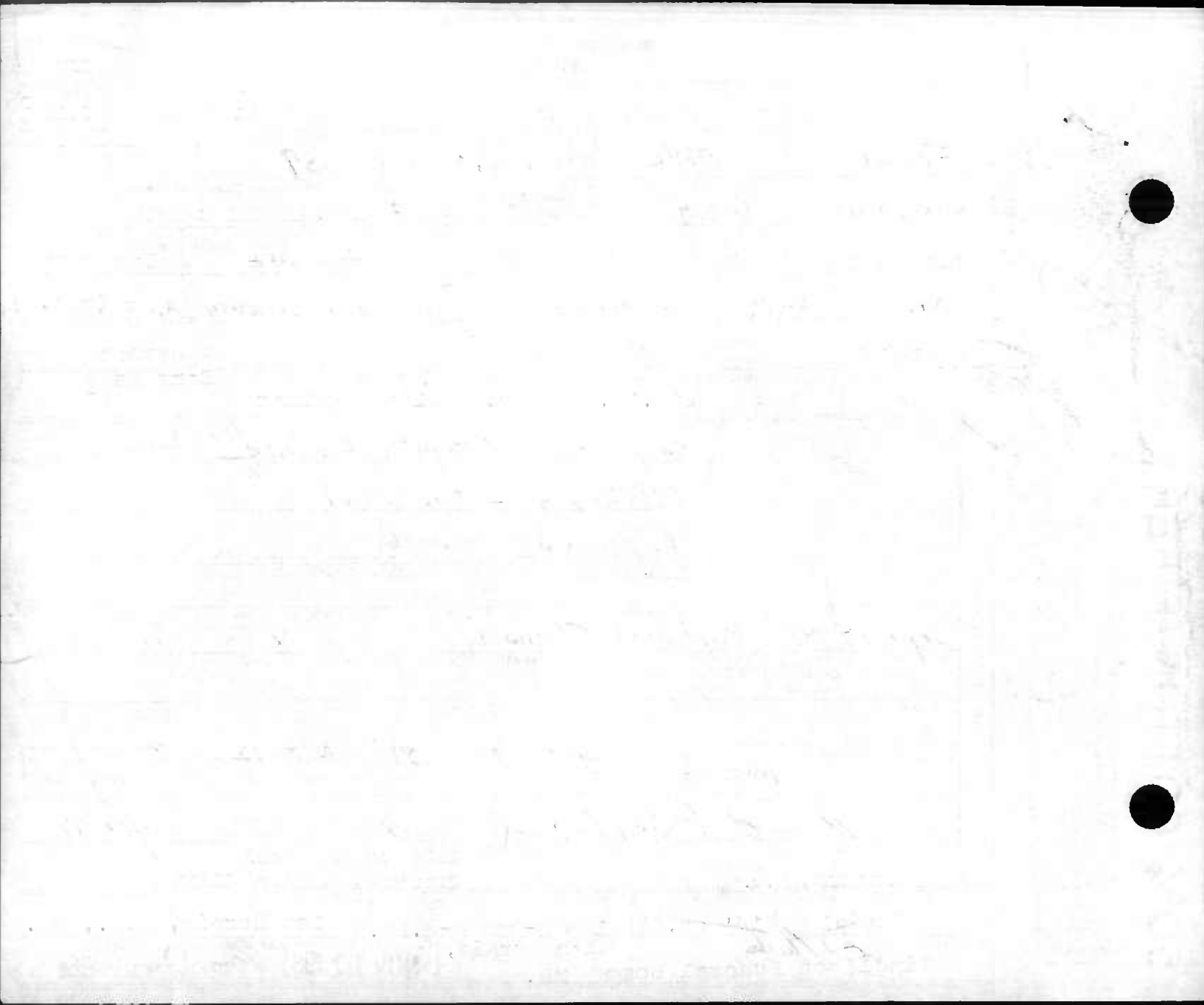
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



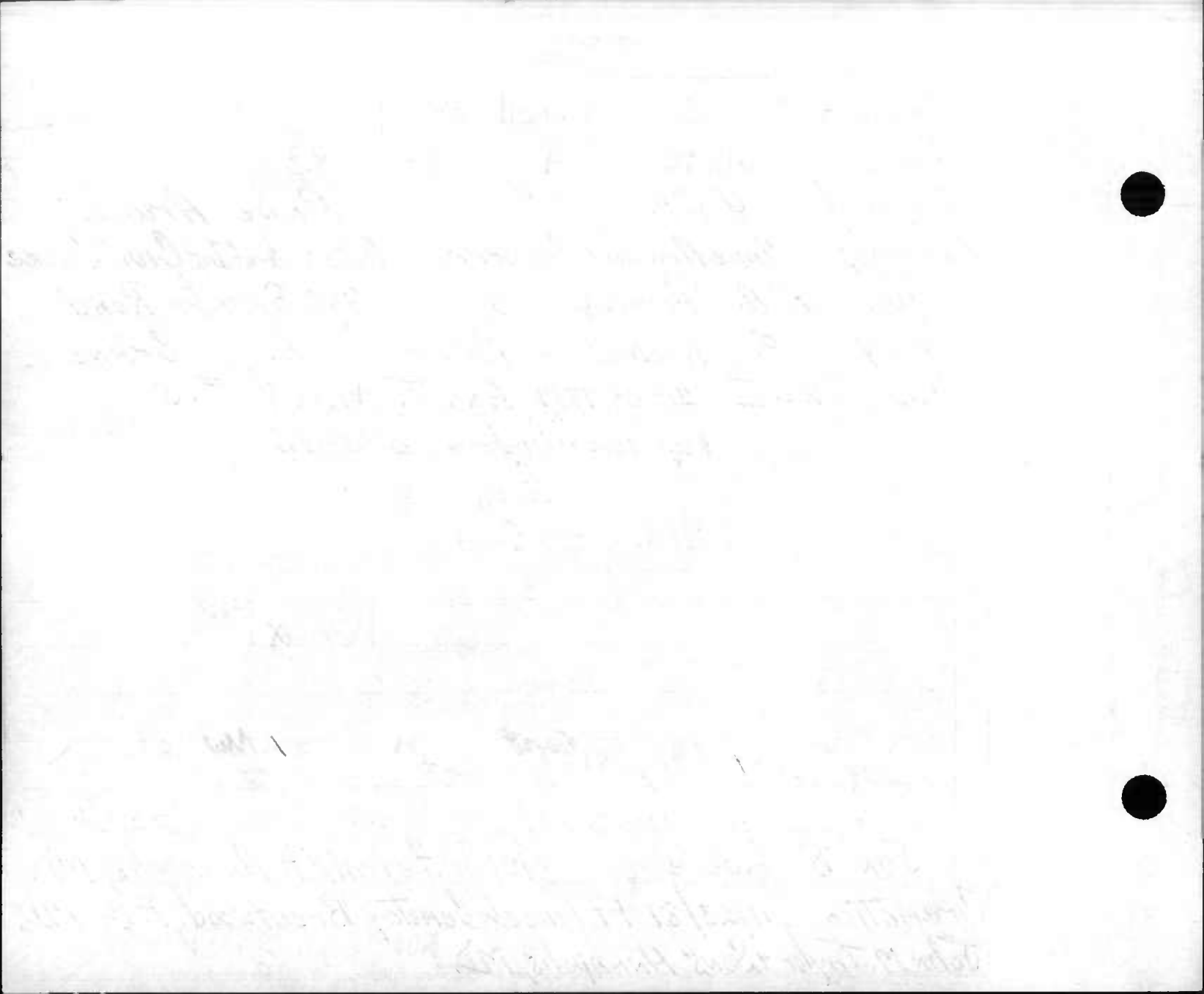
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause of death.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO. 81 27945   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Maynard C Nicholl Sr.  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11-21-81   |  |   |  | 2b. HOUR<br>30pM   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 9 98  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>England  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel MD   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Annapolis  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Anne Arundel General |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Asst Director of Ins. Civil Service |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>MD.   |  | 13b. COUNTY<br>H. A.  |  | 13c. CITY OR TOWN<br>Annapolis  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>         |  | 13e. STREET ADDRESS<br>842 Bywater Road  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>HARRY F. Nicholl  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>SARA A. CRANE  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR DATES)<br>WWII 212-05-9739  |  | 17. INFORMANT<br>ADDRESS<br>ANN T. Nicholl #13  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause pertaining to death, and in Part I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Exploded Abdominal Aortic</u><br>4413<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerosis</u> |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                           |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>Sept</u> 19 <u>78</u> to <u>21 Nov</u> 19 <u>81</u> that (I) (we) lost saw the deceased alive on <u>21 Nov</u> 19 <u>81</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                           |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Jon B. Lowe MD</u>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><u>22 Nov 81</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Jon B. Lowe  |  |   |  | 22e. ADDRESS<br>121 Cathedral St. Annapolis, MD.  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  |   |  | 23b. DATE<br>11/23/81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Ft. Lincoln Cemetery  |  | 23d. LOCATION<br>Brentwood P.G. MD.  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>John M. Taylor & Sons   |  |   |  | ADDRESS<br>Annapolis, MD.   |  | DATE REC'D. BY REGISTRAR<br>NOV 24 1981   |  | REGISTRAR'S SIGNATURE<br><u>Ann</u>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

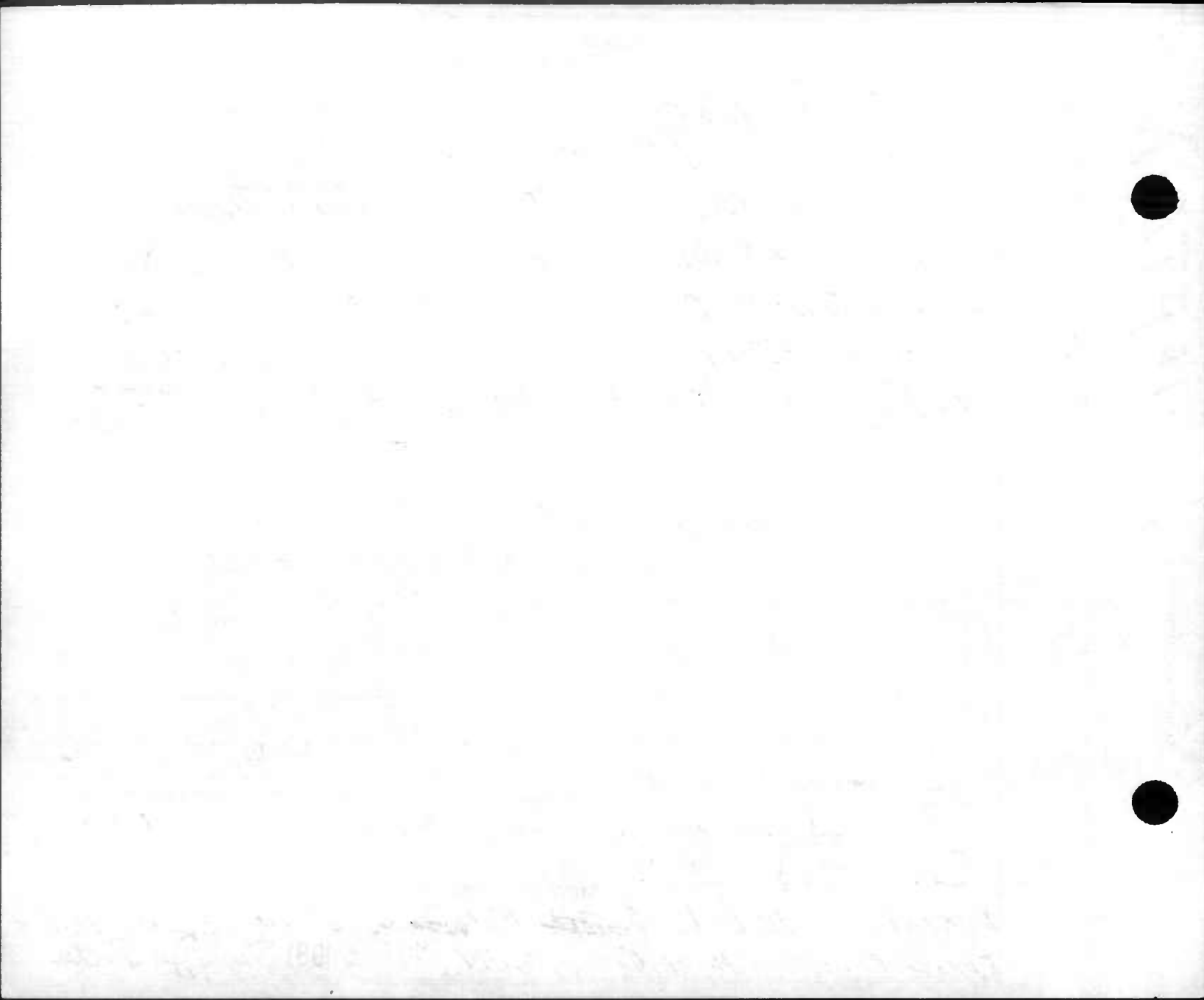
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| FOR<br>1. STATE<br>REGISTRAR   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  | 8 1 2 7 9 4 6<br>REG. NO.   |  |
|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>DORA MAE NORRIS   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>11-1-81                            |   | 2b. HOUR<br>12 30 AM                     |
| 3. SEX<br>Female   | 4. RACE<br>White   | 5. DATE OF BIRTH MONTH DAY YEAR<br>Oct 25, 1930   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN.<br>51                                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>South Carolina  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Annapolis   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>AA. GENERAL HOSP. |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Nurse |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>RN. |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Calvert  | 13c. CITY OR TOWN<br>Owings  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>John E. Mitchell  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary E. Gordon  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES <input type="checkbox"/> OR UNKNOWN <input type="checkbox"/> )<br>No  |  | 16b. SOCIAL SECURITY NO.<br>251 44 6741   |  | 17. INFORMANT ADDRESS<br>Melvin A. Norris SAME AS DECEASED                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) Cancer of Breast<br>1749<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a) _____ |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1978, 19 to 10/31/81, 19 that (I) (we) last saw the deceased alive on 10/31/81, 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.   |  |   |  |   |  |
| 22b. SIGNATURE<br>Stanley P. Watkins   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>11/1/81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Stanley P. Watkins  |  | 22e. ADDRESS  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>11/3/81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Southern Mea. Garden                                      |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Dunkirk Cal MD  |  | 23e. DATE REC'D. BY REGISTRAR<br>NOV 5 1981   |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>Ransch Funeral Home   |  | 24b. ADDRESS<br>Owings, Md.   |  |   |  |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (1))  
15M 2/80

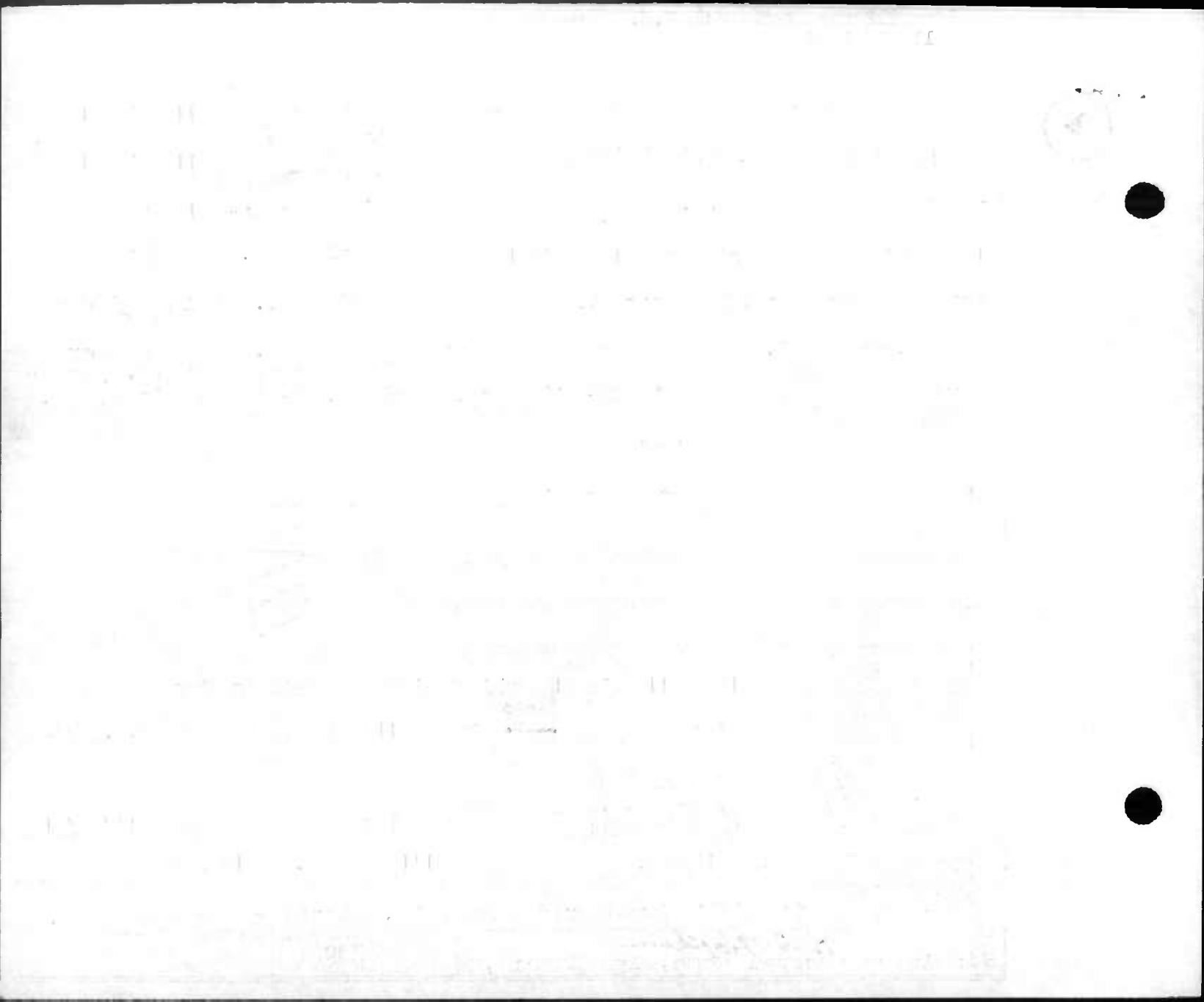
Item 21f per phone with M.E.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |                  |   |                              |   |  |
|--|------------------|---|------------------------------|---|--|
| 1. FOR STATE REGISTRAR<br>11/30/81 gj  |                  | 2. DATE KNOWN OF DEATH ESTIMATED<br>11 21 19 81                       |                              | 2b. HOUR<br>M 2:10P   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Antonia Josepha Orr   |                  | 2c. DATE PRONOUNCED DEAD<br>11 21 19 81                               |                              | 2d. HOUR<br>M   |  |
| 3. SEX<br>Female   | 4. RACE<br>White | 5. DATE OF BIRTH<br>Feb. 3, 1907                                      | 6. AGE (IN YEARS)<br>74 YRS. | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                |                              | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                           |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel County, MD.   |                  | 10. CITY OR TOWN OF DEATH<br>Glen Burnie                              |                              | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>North Arundel Hospital  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Self Emp.   |                  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Farm                             |                              | 13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland<br>13b. CITY OR TOWN Anne Arundel<br>13c. CITY OR TOWN Pasadena |  |
| 14. FATHER'S NAME<br>FIRST Innocence<br>MIDDLE P.<br>LAST Jirak  |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST Marie<br>MIDDLE A.<br>LAST Kaisler  |                              | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) No   |  |
| 17. SOCIAL SECURITY NO.<br>212-36-5172   |                  | 18. INFORMANT (daughter)<br>Mrs. Marie G. Davis Pasadena, Md.         |                              | 19. ADDRESS 8996 Ft. Smallwood Road   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Asphyxia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <u>Chest compression</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |                  |   |                              |   |  |
| 19a. DATE OF OPERATION   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                     |                              | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>1 P.M. 11 21 19 81 |                              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>Subject pinned beneath tractor   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>farm   |                              | 21f. LOCATION<br>CITY OR TOWN 8996 Ft. Smallwood Rd, Pasadena, A.A., Md.<br>COUNTY Howard<br>STATE Md.  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .  |                  |   |                              |   |  |
| ACTUAL SIGNATURE<br>Thomas D. Smith  |                  | TITLE (SPECIFY)<br>Deputy Chief                                       |                              | DATE SIGNED<br>11/22/81   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) Thomas D. Smith, M.D.   |                  | ADDRESS<br>111 Penn St. Balto., Md.                                   |                              |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) Burial  |                  | 23b. DATE<br>11/25/81   |                              | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem. Pk.  |  |
| 23d. LOCATION<br>CITY OR TOWN Elkridge<br>COUNTY Howard<br>STATE Md.   |                  | 23e. DATE REC'D BY REGISTRAR<br>NOV 23 1981                           |                              |   |  |
| 24. FUNERAL DIRECTOR<br>NAME R. D. Hopkins   |                  | 25a. DATE REC'D BY REGISTRAR<br>NOV 23 1981                           |                              |   |  |
| 25b. REGISTRAR'S SIGNATURE<br>James J. Nathan  |                  |   |                              |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 9 4 8

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |  |   |
|---|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>M A A V I V K P A D O Y  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 7 87   |  | 2b. HOUR<br>2:05 PM   |
| 3. SEX<br>Male  | 4. RACE<br>Caucasian   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8-25-31   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>50 YRS.   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel Co. MD.   |  |   |
| 10. CITY OR TOWN OF DEATH<br>Annapolis  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Anne Arundel Hospital | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Self-employed   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Tree Expert   |  |   |
| 13a. STATE<br>Md.   | 13b. COUNTY<br>Anne Arundel  | 13c. CITY OR TOWN<br>Edgewater  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 13e. STREET ADDRESS<br>3815 Muddy Creek Rd.  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Robert C. Paddy   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Myrtle Estep   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>yes   | 16b. SOCIAL SECURITY NO.<br>(YES, GIVE WAR OR DATES)<br>Korean   | 17. INFORMANT<br>ADDRESS<br>Barbara M. Paddy same as 13 a-e   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ventricular arrhythmia</u><br>4149<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ischemic heart disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>minutes<br>3 years. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hypertension</u>  |  |   |  |  |   |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/10</u> 19 <u>74</u> , to <u>12/7</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11/1</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |   |  |  |   |
| 22b. SIGNATURE<br><u>Gerard Church</u>  |  | DEGREE<br>M.D.  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>11/4/87</u>                                  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GERARD CHURCH  |  | 22e. ADDRESS<br>8 EVE ARUNDEL ROAD SEVERNA PARK MD 21146  |  |  |   |
| 23a. BURIAL-CREMAATION, REMOVAL<br>Burial   | 23b. DATE<br>11-11-81  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lakemont Memo. Gardens  | 23d. LOCATION<br>Davidsonville, Md. STATE  |  |   |
| 24. FUNERAL DIRECTOR<br>Beall Funeral Home, 1212 West Street, Annapolis, Md.  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 12 1981  | 25b. REGISTRAR'S SIGNATURE<br><u>James J. Nether</u>   |  |   |

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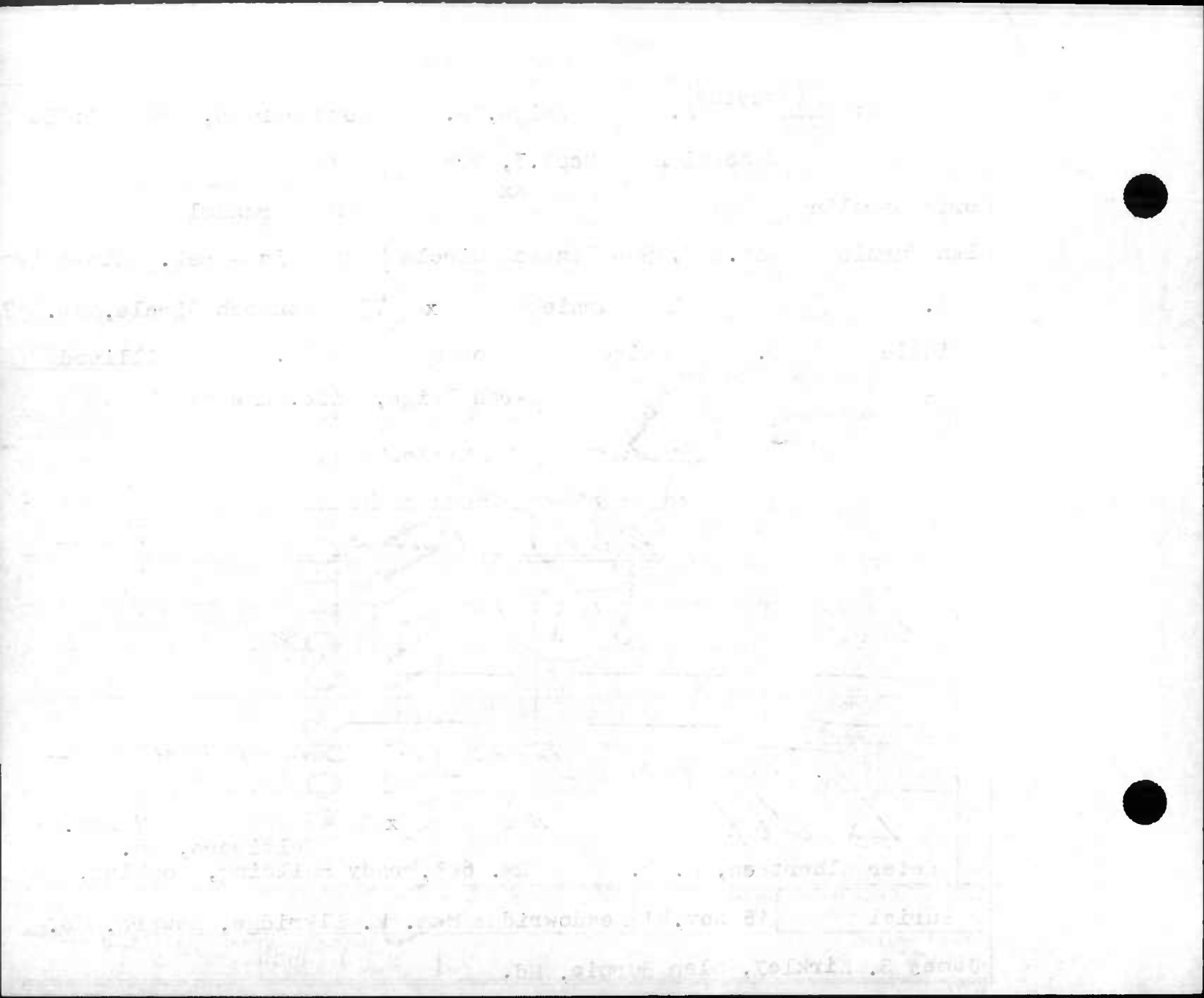
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 30M 2/80  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |   | 8 1 2 7 9 4 9 |  |
|--|--|--|--|---|--|--|--|--|---|---------------|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |  |   |  |  |  |  |   |               |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Stephen (Steven) L. Paige, Sr.</b>  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 15, 1981</b>                            |  | 2b. HOUR<br><b>1:15pm</b>  |   |               |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 3, 1906</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |   |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>North Carolina</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel</b> MD.                            |  |  |   |               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Glen Burnie</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Apt. 817, 7900 Benesch Circle</b>                |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mechanic - Ref.</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Automotive</b>   |   |               |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>   |  |  |  |   |  | 13b. COUNTY<br><b>AA</b>   |  | 13c. CITY OR TOWN<br><b>Glen Burnie</b>  |   |               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Willie D. Paige</b>   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rowena E. Hilliard</b>                 |  |  |   |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |  | 17. INFORMANT<br>ADDRESS<br><b>Sarah Paige, wife, same as 13</b>  |  |  |  |  |   |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO VASCULAR COLLAPSE</b><br><b>1850</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>DENUTRITION + MALNUTRITION</b><br>(c) <b>PROSTATIC CANCER</b> |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 MONTHS</b><br><b>7 YEARS</b> |               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |  |  |  |   |               |  |
| 19a. DATE OF OPERATION<br><b>NONE</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>NONE</b>  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |   |               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |   |               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>SEPTEMBER 9, 1981</b> , to <b>NOVEMBER 15, 1981</b> , that (I) (we) last saw the deceased on <b>NOVEMBER 2, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (not) view the body after death.          |  |  |  |   |  |  |  |  |   |               |  |
| 22b. SIGNATURE<br><b>Peter Albertsen</b>   |  | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  |  |  | 22c. DATE SIGNED<br><b>17 Nov. 81</b>  |   |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Peter Albertsen, M. D.</b>   |  |  |  | 22e. ADDRESS<br><b>Baltimore, Md.<br/>Rm. 603, Brady Building, Hopkins,</b>   |  |  |  |  |   |               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>18 Nov. 81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Mem. Pk.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Elkridge, Howard</b>                      |  |  |   |               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>James S. Kirkley, Glen Burnie, Md.</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 17 1981</b>   |  | 25b. REGISTRAR<br><b>James S. Kirkley</b>  |  |  |   |               |  |

MEDICAL CERTIFICATION



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 9 5 0

REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>HOLLIE EDWARD PARKER</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 3 81</b>                                   |  | 2b. HOUR<br>M<br><b>A</b>  |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>NEGRO</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 10 1900</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD.</b>                  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>ANNAPOLIS</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>358 General Highway</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>WELL DRILLER</b> | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b>  |   |   | 13b. COUNTY<br><b>A.A.</b>  | 13c. CITY OR TOWN<br><b>ANNAPOLIS</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GEORGE W. PARKER</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ISABELL BARKER</b>                  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>218-14-3250</b>  | 17. INFORMANT<br>ADDRESS<br><b>ELLEN FOWLER 825 Bestgate Rd. Annapolis, Md.</b>         |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIC ARREST</b>   |   |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>2-3 min.</b>   |
| 1850<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |   |   |   |  | DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>GENERAL DEBILITY</b><br><b>3-4-months</b>   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CARCINOMA OF THE PROSTATE</b><br><b>10 years</b>  |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>GENERALIZED ARTERIOSCLEROSIS</b>   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 16, 19 71</b> to <b>Oct 16, 19 81</b> , that (I) (we) lost saw the deceased alive on <b>Oct 16, 19 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Richard E. Cook, M.D.</b>   |   |   |   | 22c. DATE SIGNED<br><b>11/6/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RICHARD E. COOK, M.D.</b>  |   |   |   | 22e. ADDRESS<br><b>113 Cathedral Street Annapolis, Md. 21401</b>               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  | 23b. DATE<br><b>11-7-1981</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>FOWLERS U.M. CHURCH CEME.</b>  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Annapolis, A.A. Maryland</b>           | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 9 1981</b>                             |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b>   |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>James Van Natten</b>                                   |  |  |

1981-1982

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

2.

P.C.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

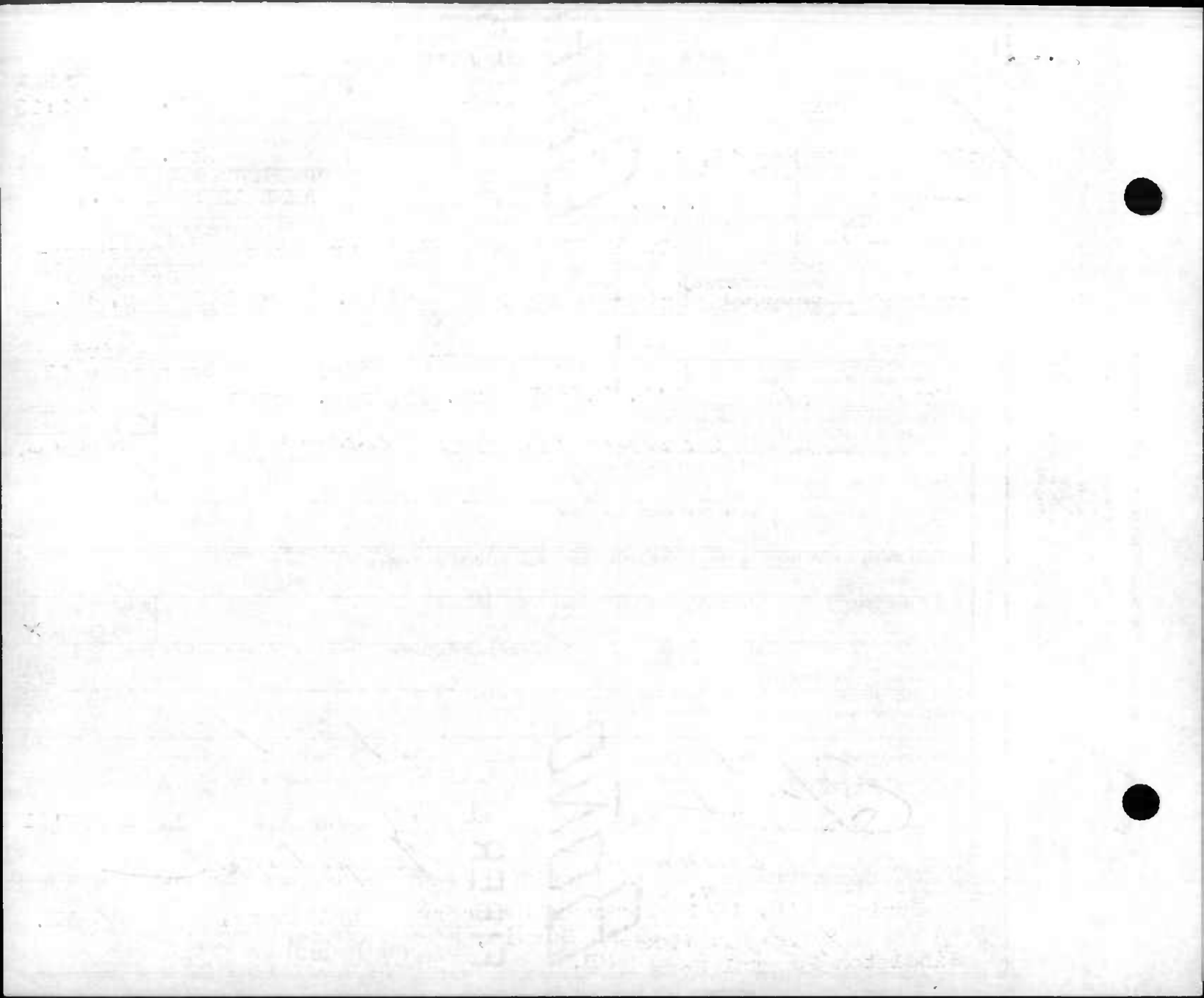
27751

|  |         |  |                                    |   |                               |   |   |                              |       |               |          |          |
|--|---------|--|------------------------------------|---|-------------------------------|---|---|------------------------------|-------|---------------|----------|----------|
| FOR<br>1- STATE<br>REGISTRAR   |         | DECEASED NAME<br>(TYPE OR PRINT)   |                                    | FIRST   | MIDDLE                        | LAST  | 20. DATE KNOWN<br>OF ESTI-<br>DEATH MATED |                              | MONTH | DAY           | YEAR     | 21. HOUR |
|  |         | Dale   |                                    |   | (nmn)                         | Parks   |   |                              | Nov.  | 6             | 1981     | 1:13     |
| 1. SEX   | 4. RACE | 5. DATE OF BIRTH<br>MONTH DAY YEAR   | 6. AGE (IN YEARS<br>LAST BIRTHDAY) | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN | 22. DATE<br>PRONOUNCED<br>DEAD                                      |   | MONTH                        | DAY   | YEAR          | 23. HOUR |          |
| Male   | White   | May 10, 1900   | 81 YRS.                            |   |                               | Nov. 6, 1981  |   |                              |       |               | M        |          |
| 7. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |                                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                               | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |   |                              |       |               |          |          |
| Maryland   |         | U.S.A.   |                                    |   |                               | ANNE ARUNDEL CO., MD.   |   |                              |       |               |          |          |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                    | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)  |                               | 12b. KIND OF BUSINESS<br>OR INDUSTRY                                |   |                              |       |               |          |          |
| Glen Burnie  |         | NORTH ARUNDEL HOSPITAL   |                                    | Carpenter   |                               | Construction  |   |                              |       |               |          |          |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |         | 13b. COUNTY  |                                    | 13c. CITY OR TOWN   |                               | 13d. INSIDE CITY LIMITS?  |   | 13e. STREET ADDRESS          |       | 13f. ANN, MD. |          |          |
| Maryland   |         | Somerset   |                                    | Princess Ann  |                               | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | Rt. 3 Box 296                |       |               |          |          |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |                                    | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |                               | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT (Wife) ADDRESS |       | Same as # 13  |          |          |
| Thomas   |         | Ellen  |                                    | No  |                               | 213.07.6507   |   | Mrs. Lydia P. Parks          |       |               |          |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u><br>4149 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |         |  |                                    |   |                               |   |   |                              |       |               |          |          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |         |  |                                    |   |                               |   |   |                              |       |               |          |          |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                                    | 20. AUTOPSY?  |                               | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |                              |       |               |          |          |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                               |   |   |                              |       |               |          |          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |                                    | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                               |   |   |                              |       |               |          |          |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |  |                                    |   |                               |   |   |                              |       |               |          |          |
| ACTUAL<br>SIGNATURE  |         | TITLE (SPECIFY)  |                                    | M.D.  |                               | MEDICAL EXAMINER  |   | DATE<br>SIGNED               |       | 6 NOV'81      |          |          |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |         | ADDRESS  |                                    |   |                               |   |   |                              |       |               |          |          |
| FLINHARDT  |         | Baltimore, Md.   |                                    |   |                               |   |   |                              |       |               |          |          |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |         | 23b. DATE  |                                    | 23c. NAME OF CEMETERY OR CREMATORY  |                               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |   |                              |       |               |          |          |
| Burial   |         | Nov. 10, 1981  |                                    | Parkwood Cemetery   |                               | Baltimore, MD.  |   |                              |       |               |          |          |
| 24. FUNERAL DIRECTOR<br>NAME   |         | 25a. DATE REC'D. BY REGISTRAR  |                                    | 25b. REGISTRAR'S SIGNATURE  |                               |   |   |                              |       |               |          |          |
| H.B. Singleton   |         | NOV 9 1981   |                                    | James J. [Signature]  |                               |   |   |                              |       |               |          |          |
| Singleton Funeral Home   |         | MD.  |                                    |   |                               |   |   |                              |       |               |          |          |

BP

DHMH - 17  
(VR A15 ME (5))  
15M7/76

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETURNED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove co-bonopapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 9 5 2

REG. NO.

|   |   |   |  |  |                      |
|---|---|---|--|--|----------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>James Wallace Perry, Jr.   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 19 81  |  | 2b. HOUR<br>11:30 AM |
| 3. SEX<br>Male  | 4. RACE<br>Caucasian  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>08 17 30  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>51 YRS  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                     |                      |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Tenn   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel MD  |  |                      |
| 10. CITY OR TOWN OF DEATH<br>Annapolis  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Anne Arundel Genl Hosp |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Sales Rep.                             | 12b. KIND OF BUSINESS OR INDUSTRY<br>Petroleum                                       |                      |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br>MD  | 13c. COUNTY<br>A.A.   | 13d. CITY OR TOWN<br>Annapolis  | 13e. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> | 13f. STREET ADDRESS<br>914 Lynch Drive   |                      |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Wallace Perry, Sr.  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Eloise Ussery  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes Korean                         |  |                      |
| 16b. SOCIAL SECURITY NO.<br>410-444-6564  |   | 17. INFORMANT<br>Carol Lynch Perry  |  | ADDRESS<br>Same as #13   |                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) PANCOAST Tumor Lung<br>1623<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ |   |   |  |  |                      |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                      |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |   |  |  |                      |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |                      |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |                      |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/6/81 to 11/19/81, 1981, that (I) (we) lost the deceased alive on 11/19/81, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.   |   |   |  |  |                      |
| 22b. SIGNATURE<br>S P WATKINS   |   | DEGREE  |  | 22c. DATE SIGNED<br>11/19/81   |                      |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>S P WATKINS  |   | 22e. ADDRESS<br>121 Cathedral Street, Annapolis, MD   |  |  |                      |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   | 23b. DATE<br>Nov. 20, 1981  | 23c. NAME OF CEMETERY OR CREMATORY<br>Ft. Lincoln   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brentwood PG MD                        |                      |
| 24. FUNERAL DIRECTOR<br>NAME<br>Taylor Funeral Chapel, Annapolis, MD  |   | 25a. ADDRESS  |  | 25b. RECEIVED BY REGISTRAR'S SIGNATURE<br>NOV 23 1981 Frances Jean Nathan            |                      |

MEDICAL CERTIFICATION

121 Cathedral Street, Hartford, Conn.  
L. M. ...  
...

...

...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 9 5 3

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |                            |   |  |   |  |   |  |
|--|--|--|--|---|----------------------------|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LATONYA PINCKNEY</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 26 81</b> |   | 2b. HOUR<br><b>5 30 PM</b> |   |  |   |  |   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 5 63</b>   |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>18</b> YRS                                    |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>18</b>  |  | 8. IF UNDER 24 HRS<br>HOURS MIN.<br><b>5 30</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>D.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>A.A. Co.</b> MD.                         |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Laurel</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>D.C. Children Center</b> |  |   |                            | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>N/A</b>      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>N/A</b>   |  |   |  |
| 13a. STATE<br><b>D.C.</b>  |  |  |  | 13b. COUNTY<br><b>NONE</b>  |                            | 13c. CITY OR TOWN<br><b>D.C.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  | 13e. STREET ADDRESS<br><b>2647 Burnney St. SE</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank M. Pinckney</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Theresa Wright</b>  |                            |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, GIVE WAR OR DATES)<br><b>NO</b>   |  |   |  |
| 16b. SOCIAL SECURITY NO.<br><b>217-88-6894</b>   |  |  |  | 17. INFORMANT<br><b>MRS. ROBERTA LITTLE</b>   |                            |   |  | 17. ADDRESS<br><b>RT. 198 LAUREL, Md.</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Collapse</b><br><b>3439</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>cerebral palsy</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |   |                            |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Profound mental retardation, seizure</b>   |  |  |  |   |                            |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |                            | 20a. AUTOPSY<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                            |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 5, 19 81</b> to <b>Nov. 26, 19 81</b> , that (I) (we) last saw the deceased alive on <b>Nov. 25, 19 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |                            |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>J. C. Hung MD</b>   |  |  |  | DEGREE<br><b>MD</b>   |                            |   |  | 22c. DATE SIGNED  |  |   |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Yin C. HUNG, MD</b>  |  |  |  | 22e. ADDRESS<br><b>Forest Haven, Laurel MD</b>  |                            |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>12-4-1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>FOREST HAVEN CEM.</b>  |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>LAUREL MD Md.</b>                  |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>W. W. CHAMBERS Co.</b>  |  |  |  | ADDRESS<br><b>517 11th St SE WASH. D.C.</b>   |                            |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 8 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |

BP



5

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, FILE AND EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 7/77

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                  |  |   |  |   |   |   |  |                    | REG. NO. 27954   |  |
|--|------------------|--|---|--|---|---|---|--|--------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARGARET T. PINKSTON</b>  |                  |  |   |  |   |   | 2a. DATE KNOWN OF DEATH<br>MONTH <input checked="" type="checkbox"/> 11 DAY 4 YEAR 81 |  | 2b. HOUR <b>PM</b> |  |  |
| 3. SEX <b>F</b>  | 4. RACE <b>W</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>11-23-30</b> | 6. AGE (IN YEARS LAST BIRTHDAY) <b>50 YRS.</b>  | 7. IF UNDER 1 YR. MONTHS DAYS                                      | 8. IF UNDER 24 HRS. HOURS MIN.  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>11 4 81</b>                     |   | 2d. HOUR <b>PM</b>   |                    |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>So. Africa</b>  |                  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Anne Arundel</b> MD.                          |  |                    |  |  |
| 10. CITY OR TOWN OF DEATH <b>Annapolis</b>   |                  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Anne Arundel General</b> |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SALES</b>    |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>RETAIL</b>                      |                    |  |  |
| 13a. STATE <b>Md.</b>  |                  | 13b. COUNTY <b>A.A.Co.</b>                         | 13c. CITY OR TOWN <b>DAVIDSONVILLE</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET ADDRESS <b>1111 Quince Apple Pl. 21031</b>                        |   |  |                    |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>CECIL X CALLANAN</b>   |                  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Margaret RYAN</b> |   |   |   |  |                    |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO -</b>   |                  |  | 16b. SOCIAL SECURITY NO. <b>N/A</b>   |  | 17. INFORMANT <b>FRANCIS PINKSTON</b>   |   |   | ADDRESS <b>SAN ANTONIO 3A-E</b>                                      |                    |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE <b>Coronary Artery Disease</b><br>4149<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  |                  |  |   |  |   |   |   |  |                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>                       |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |                  |  |   |  |   |   |   |  |                    |  |  |
| 19a. DATE OF OPERATION   |                  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                  |   |   |   |  |                    | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19         |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |   |  |                    |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |                  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)        |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |  |                    |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |  |   |  |   |   |   |  |                    |  |  |
| ACTUAL SIGNATURE <b>E. Linhardt</b>  |                  |  |   | TITLE (SPECIFY) <b>Deputy</b> M.D. <b>Deputy</b> MEDICAL EXAMINER  |   |   |   | DATE SIGNED <b>11.5.81</b>   |                    |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>E. LINHARDT</b>   |                  |  |   | ADDRESS <b>Annapolis, Md.</b>                                      |   |   |   |  |                    |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |                  |  | 23b. DATE <b>11-7-81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>LAKEMONT MOUN. GARDENS</b>  |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>DAVIDSONVILLE, Md.</b> |                    |  |  |
| 24. FUNERAL DIRECTOR NAME <b>William T. C... Bowie, Md.</b>  |                  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR <b>NOV 9 1981</b>                               |   | 25b. REGISTRAR'S SIGNATURE <b>Thomas J. ...</b>                      |                    |  |  |
| Beall Funeral Home, 16000 Annap. Rd.   |                  |  |   |  |   |   |   |  |                    |  |  |

MEDICAL CERTIFICATION

17

53

35

20

1

3

Received of the  
University of Chicago  
the sum of \$100.00  
for the purchase of  
the book  
The University of Chicago  
Library

Received of the  
University of Chicago  
the sum of \$100.00  
for the purchase of  
the book  
The University of Chicago  
Library

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

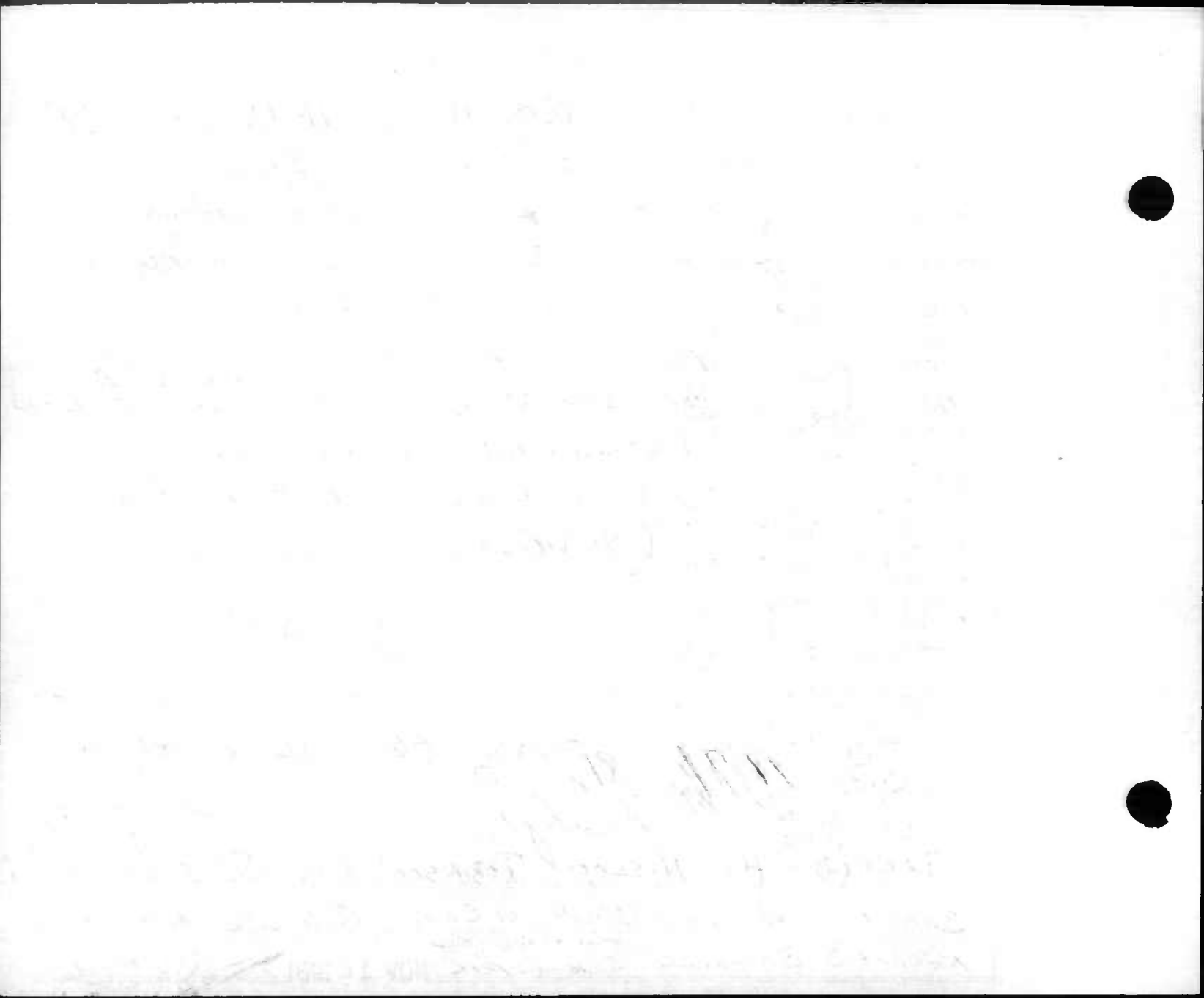
1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |   |  |  |  |
|--|--|---|--|---|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Dudley D. Placide</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-15-81</b>                     |   |  | 2b. HOUR<br><b>8A<sup>M</sup></b>   |   |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6-3-1900</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.                                     |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel</b> MD.                       |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Annapolis</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Anne Arundel Gen. Hosp.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Supervisor</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Mfg. Co.</b>   |  |  |
| 13a. STATE<br><b>MD.</b>   |  |   | 13b. COUNTY<br><b>A.A.</b>   |   | 13c. CITY OR TOWN<br><b>Severna Park</b>                                       |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>8 River Dr.</b>    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Placide</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Kirschner</b> |   |  | ADDRESS<br><b>4 River Dr.</b>   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>215-01-0106</b>                             |   | 17. INFORMANT<br><b>Shirley Schantz - Severna Park, MD.</b>                    |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Intraductal Adenocarcinoma</b><br>1551<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>of the Liver with obstruction</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Jaundice</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): |  |   |  |   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                           |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>10/7/81 19</b>       |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)     |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |  |  |  |
| 22a. I certify that (1) this hospital attended and released from <b>11/17/81</b> to <b>11-15-1981</b> , that (we) last saw the decedent alive on <b>11/17/81</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) yes and (2) did not occur after death.  |  |   |  |   |  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Donald H. Hislop</b> DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>   |  |   |  |   |  | 22c. DATE SIGNED<br><b>11/17/81</b>   |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DONALD H. HISLOP</b>   |  |   |  |   |  | 22e. ADDRESS<br><b>ROBINSON RD SEVERNA PK, MD.</b>                                    |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>11-18-81</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodfield Cem.</b>                    |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Galesville A.A. MD.</b>                        |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Robert S. Barranco 501 Ritchie Hwy Severna Park</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 19 1981</b>                                   |   |  |  |  |
|  |  |   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                      |   |  |  |  |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH-17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

27956

|  |                  |  |  |   |   |  |   |  |
|--|------------------|--|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>George Andrew Poe   |                  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>11 5 1981              |   |   | 2b. HOUR<br>P M  |   |  |
| 3. SEX<br>Male   | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Apr. 27, 1925  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>56 YRS.                  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.  | 7c. DATE PRONOUNCED DEAD<br>11 5 1981  | 2d. HOUR<br>P M   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Tennessee   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO.                               |   |  |
| 10. CITY OR TOWN OF DEATH<br>Annapolis   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Anne Arundel General |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Draftsman    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>N.S.R. Lab   |  |
| 13a. STATE<br>Maryland   |                  |  | 13b. CITY OR TOWN<br>Anne Arundel                              |   | 13c. STREET ADDRESS<br>1910 Norwich Road                                      |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William Poe  |                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Alice Tallant |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes |   |  |
| 16b. SOCIAL SECURITY NO.<br>W.W. II 413.24.5674  |                  |  | 17. INFORMANT (Wife)<br>Mrs. Juanita R. Poe                    |   |   | ADDRESS<br>Same as # 13  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE<br>4149 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) }<br>(c) }  |                  |  |  |   |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                  |  |  |   |   |  |   |  |
| 19a. DATE OF OPERATION   |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?              |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19     |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)    |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                  |  |  |   |   |  |   |  |
| ACTUAL SIGNATURE<br>E. Linhardt MD   |                  |  | TITLE (SPECIFY)<br>M.D. Deputy                                 |   |   | DATE SIGNED<br>11.5.81   |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>E. Linhardt  |                  |  | ADDRESS<br>Annapolis, MD                                       |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |                  | 23b. DATE<br>9 Nov. 81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Balto. Nat'l. Cem.  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, MD.                 |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>J. Easter<br>Address<br>Singleton Funeral Home MD.   |                  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 9 1981   |   | 25b. REGISTRAR'S SIGNATURE<br>Francis J. [Signature]                         |   |  |

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DHMH - 16 50M 1/B1  
(VRA 15, 4)

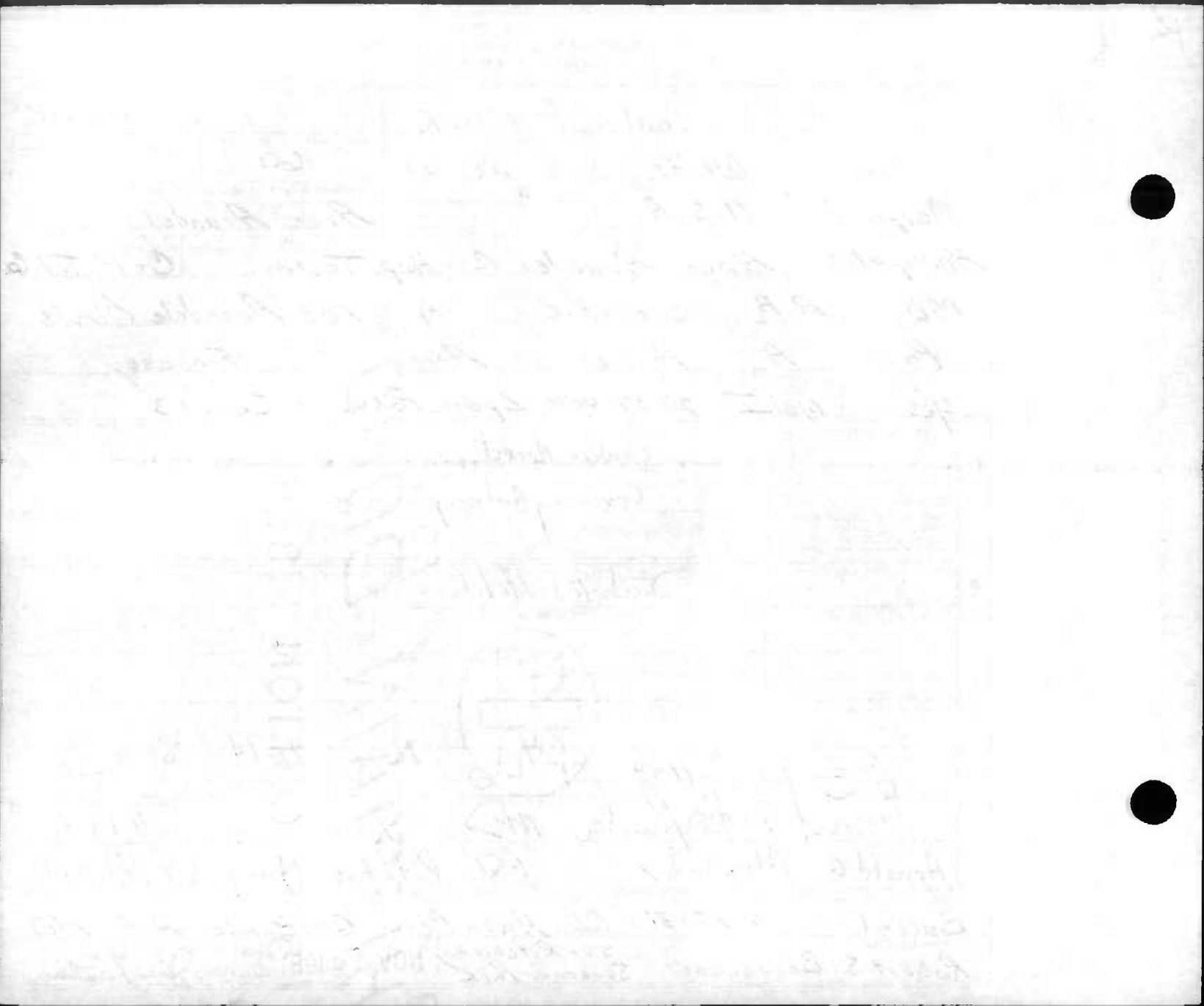
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 81 27957   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ARMAND Paul POHLNER</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>14</b> YEAR <b>81</b>   |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>8</b> DAY <b>26</b> YEAR <b>21</b>   |  | 2b. HOUR<br><b>6:23 P.M.</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Annapolis</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Anne Arundel Gen Hosp. Testman</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>C + P Tel. Co.</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD.</b>  |  | 13b. COUNTY<br><b>A.A.</b>   |  | 13c. CITY OR TOWN<br><b>Severna Park</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |  |
| 14. FATHER'S NAME<br>FIRST <b>Paul</b> MIDDLE <b>A.</b> LAST <b>Pohlner</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Anna</b> MIDDLE <b>Finnese</b> LAST <b>sey</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>218-09-4070</b>   |  | 17. INFORMANT<br>ADDRESS <b>Lydia Pohlner - Sec. 13</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>4149</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Coronary Artery Disease.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Diabetes Mellitus</b>  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>11-14-81</b> to <b>11-14-81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Arnold G. Alexander</b>  |  |  |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11-15-81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Arnold G. Alexander</b>   |  |  |  | 22e. ADDRESS<br><b>650 Ritchie Hwy. S.P.Md 21146</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  | 23b. DATE<br><b>11-17-81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie A.A. MD.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Robert S. Barranco</b> ADDRESS <b>501 Ritchie Ave. Severna Park</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 19 1981</b> REGISTRAR'S SIGNATURE <b>James J. Nathan</b>   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 15 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/B1  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  | 81 27958 |  |
|---|--|--|--|---|--|--|--|---|--|----------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.   |  |   |  |  |  |   |  |          |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Kathleen M Pretz</i>  |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>11 25 81</i>  |  | 2b. HOUR<br><i>11<sup>30</sup> AM</i>   |  |          |  |
| 3. SEX<br><i>F</i>  |  | 4. RACE<br><i>white</i>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>03 02 99</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><i>82</i>  |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |          |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Bedford Penn.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>ANNE ARUNDEL Co MD</i>                            |  |   |  |          |  |
| 10. CITY OR TOWN OF DEATH<br><i>ANNAPOLIS</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>ANNE ARUNDEL GENERAL Hosp</i> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>housewife household</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |          |  |
| 13a. STATE<br><i>MD</i>   |  | 13b. COUNTY<br><i>AA Co</i>  |  | 13c. CITY OR TOWN<br><i>CHURCHTON</i>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>5548 EXETER ST</i>  |  |          |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>John McLaughlin</i>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Miriam Beegle</i>   |  |   |  |  |  |   |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>no</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>572-42-6353</i>   |  | 17. INFORMANT ADDRESS<br><i>George B. Leyden 47 Ridge Crest Rd. Stanford Conn.</i>  |  |  |  |   |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Lung Cancer</i><br><i>1629</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>—</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>—</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>months</i> |  |  |  |   |  |  |  |   |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>—</i>   |  |  |  |   |  |  |  |   |  |          |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><i>NO injury</i>  |  |  |  |   |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Aug 19 77</i> to <i>11/25/81</i> 19 <i>81</i> . that (I) (we) lost saw the deceased alive on <i>11/25/81</i> 19 <i>81</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |   |  |          |  |
| 22b. SIGNATURE <i>C.H. Wirth MD</i>   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |  |  | 22c. DATE SIGNED<br><i>11/25/81</i>   |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>C.H. Wirth MD</i>   |  | 22e. ADDRESS<br><i>Lothian, Md</i>   |  |   |  |  |  |   |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>11/28/81</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Our Lady of Sorrows</i>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Owensville, Md.</i>                            |  |   |  |          |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><i>Hardesty Funeral Home 12 Ridgely Ave. Ann. Md.</i>  |  |  |  | 25a. DATE REC'D BY REGISTRAR<br><i>NOV 27 1981</i>  |  |  |  |   |  |          |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Frances Jan Wirth</i>  |  |  |  |   |  |          |  |

MEDICAL CERTIFICATION

1. *Amphispiza bilineata*

2. *Amphispiza bilineata* - *Amphispiza bilineata*

3. *Amphispiza bilineata* - *Amphispiza bilineata*

4. *Amphispiza bilineata* - *Amphispiza bilineata*

5. *Amphispiza bilineata* - *Amphispiza bilineata*

6. *Amphispiza bilineata* - *Amphispiza bilineata*

7. *Amphispiza bilineata* - *Amphispiza bilineata*

8. *Amphispiza bilineata* - *Amphispiza bilineata*

9. *Amphispiza bilineata* - *Amphispiza bilineata*

10. *Amphispiza bilineata* - *Amphispiza bilineata*

11. *Amphispiza bilineata* - *Amphispiza bilineata*

12. *Amphispiza bilineata* - *Amphispiza bilineata*

13. *Amphispiza bilineata* - *Amphispiza bilineata*

14. *Amphispiza bilineata* - *Amphispiza bilineata*

15. *Amphispiza bilineata* - *Amphispiza bilineata*

16. *Amphispiza bilineata* - *Amphispiza bilineata*

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (1))  
15M 2/80

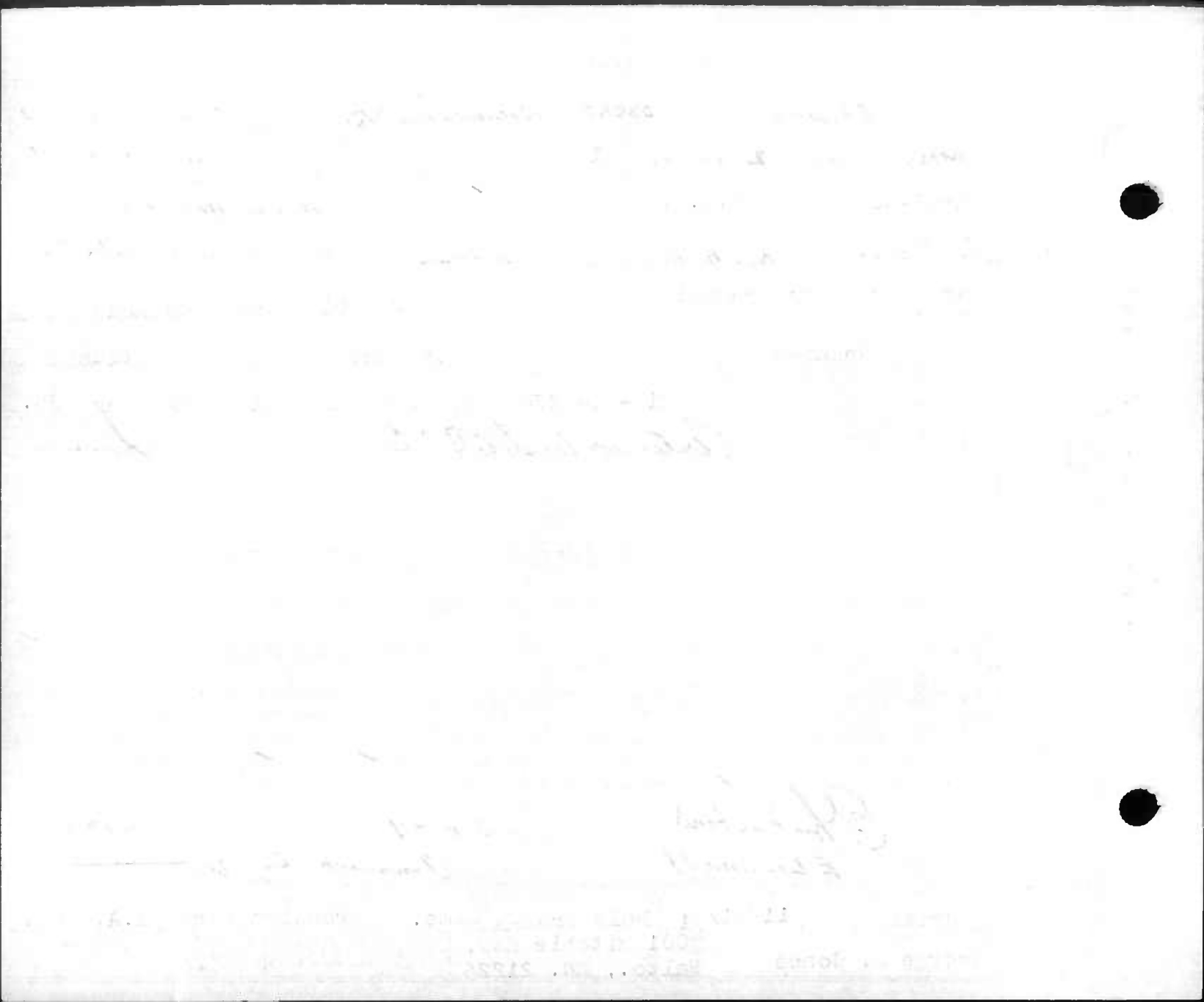
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- REGISTRAR

|   |                     |   |  |   |                            |
|---|---------------------|---|--|---|----------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Thomas ROBERT RANDALL SR.</b>   |                     |   | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br><b>11 17 81</b> |   | 2b. HOUR<br>M<br><b>12</b> |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>W</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2 12 10</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>71</b> YRS.         | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            |
| 10. CITY OR TOWN OF DEATH<br><b>New Bernie</b>  |                     | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>North Avenue Hosp. &amp; L</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>Diesel Mechanic</b>  |                            |
| 13a. STATE<br><b>Maryland</b>   |                     | 13b. CITY OR TOWN<br><b>Pasadena</b>  |  | 13c. STREET ADDRESS<br><b>8013 Tick Neck Road</b>   |                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>  |                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Young</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218-28-3276</b>  |                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |                     | 17. INFORMANT<br><b>Mary E. Randall</b>   |  | ADDRESS<br><b>8013 Tick Neck Rd.</b>  |                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Arteriosclerosis</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |                     |   |  |   |                            |
| 19a. DATE OF OPERATION  |                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                            |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                            |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                     | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .   |                     |   |  |   |                            |
| ACTUAL SIGNATURE<br><b>E. Linhardt</b>  |                     | TITLE (SPECIFY)<br><b>Deputy</b>  |  | DATE SIGNED<br><b>11.17.81</b>  |                            |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>F. LINHARDT</b>  |                     | ADDRESS<br><b>Annapolis, Md</b>   |  |   |                            |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |                     | 23b. DATE<br><b>11/21/81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross Ceme.</b>   |                            |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>George J. Gonce</b>  |                     | ADDRESS<br><b>4001 Ritchie HWY,<br/>Balto., Md. 21225</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 23 1981</b>   |                            |
| 25b. REGISTRAR'S SIGNATURE<br><b>James S. [Signature]</b>   |                     | 25c. REGISTRAR'S NAME<br><b>James S. [Signature]</b>  |  |   |                            |

CITY OR TOWN  
**Brooklyn Park** A.A. MD.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |  | REG. NO. 81 27960               |  |
|---|--|---|--|---|--|--|--|---|--|---------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>RAWLINGS MARGUERITE A Rawlings</b>  |  |   |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>13 Nov 1981</b> |   |  | 2b. HOUR MIN<br><b>11 15 AM</b> |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Nov 23 1907</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b>   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 1 YEAR HOURS MIN.   |  | IF UNDER 1 YEAR HOURS MIN.      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>ANNAP. MD.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel MD.</b>                              |  |   |  |                                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>ANNAPOLIS</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (DO NOT INCLUDE FACILITY, GIVE STREET ADDRESS)<br><b>A-A-Gen. Hosp.</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b> |                                 |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>A.A.</b>  |  | 13c. CITY OR TOWN<br><b>ANNAPOLIS</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>49 Anos Garrett Blvd</b>  |  |                                 |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Wm C. Parkinson</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>MARY A. REHN</b>   |  |  |  |   |  |                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>215 74 7372</b>  |  | 17. INFORMANT ADDRESS<br><b>Evelyn WALSH # 13</b>   |  |  |  |   |  |                                 |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Transition of chronic illness</b><br><b>2639</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>undetermined</b><br>(c) <b>undetermined</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 months</b> |  |   |  |   |  |  |  |   |  |                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Diabetes mellitus</b>   |  |   |  |   |  |  |  |   |  |                                 |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |                                 |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |                                 |  |
| 22a. I certify that (1) <del>the</del> hospital attended the deceased from <b>Oct 26</b> , 19 <b>81</b> , to <b>Nov 13</b> , 19 <b>81</b> , that (1) <del>the</del> lost saw the deceased alive on <b>Nov 13</b> , 19 <b>81</b> , and that in (my) <del>the</del> opinion death occurred on the date and hour and from the causes stated above, (b) <del>the</del> (did) <del>not</del> view the body after death.  |  |   |  |   |  |  |  |   |  |                                 |  |
| 22b. SIGNATURE<br><b>Charles W. Kinzer</b>  |  |   |  | DEGREE<br><b>MD</b>   |  |  |  | 22c. DATE SIGNED<br><b>Nov 13, 1981</b>   |  |                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CHARLES W. KINZER MD.</b>   |  |   |  | 22e. ADDRESS<br><b>ANNAPOLIS MD.</b>  |  |  |  |   |  |                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>11-16-81</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CEDAR BLUFF</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>ANNAPOLIS MD.</b>                              |  |   |  |                                 |  |
| 24. FUNERAL DIRECTOR NAME<br><b>John M. Taylor Sons</b>   |  |   |  | ADDRESS<br><b>ANNAPOLIS MD</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 16 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Frances Jean Nathan</b>  |  |                                 |  |

MEDICAL CERTIFICATION

11

12 Nov 1941

13 Nov 1941

1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1/71 30M  
(VR A15 (4))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |   |   |  |  |
|--|--|---|--|---|---|---|---|--|--|
| 1. DECEASED-NAME (Type or print) <u>Ro BONG S. Bong</u>  |  |   |  |   | 2a. DATE OF DEATH<br>Month <u>11</u> Day <u>19</u> Year <u>87</u>   |   |   | 2b. HOUR <u>3AM</u>  |  |
| 3. SEX <u>FEMALE</u>   |  | 4. RACE <u>KOREAN</u>                     |  | 5. DATE OF BIRTH <u>MAY 8. 1896</u>   |   | 6. AGE (In years lost birthday) <u>85</u> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS <u></u> DAYS <u></u>                       |  |
| 7a. BIRTHPLACE (State or foreign country) <u>KOREA</u>   |  | 7b. CITIZEN OF WHAT COUNTRY? <u>KOREA</u> |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH <u>ANNE ARUNDEL</u>  |   |  |  |
| 10. CITY OR TOWN OF DEATH <u>ANNAPOLIS</u>   |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>ANNE ARUNDEL GEN. HOSP.</u>                                    |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>HOUSEMAKER</u> |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                            |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD</u>  |  |   | 13b. COUNTY <u>ANNE ARUNDEL</u>  |   | 13c. CITY OR TOWN <u>ANNAPOLIS</u>                                  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER <u>130 HEARNE ROAD</u>                |
| 14. FATHER'S NAME First <u></u> Middle <u></u> Last <u>LIM</u>   |  |   | 15. MOTHER'S MAIDEN NAME First <u></u> Middle <u>NOT AVAILABLE</u> Last <u></u>  |   |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>   |  |   | 16b. SOCIAL SECURITY NO. <u>NONE</u>   |   | 17. INFORMANT Address <u>WON HO RO - 130 HEARNE RD. ANNAPOLIS.</u>  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4149</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Congestive heart failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Ischemic heart disease</u> |  |   |  |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Weeks</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                    |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21a. ACCIDENT WAS CONTRIBUTING <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. <u></u> Month <u></u> Day <u></u> Year <u>19</u><br>P.M. <u></u>  |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)                           |   |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |   |   | 21f. LOCATION Street or R.F.D. No. <u></u> City or Town <u></u> County <u></u> State <u></u>              |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/11</u> , 19 <u>87</u> , to <u>11/18</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11/18</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                          |  |   |  |   |   |   |   |  |  |
| 22b. SIGNATURE <u>Gerard Church</u>  |  |   | DEGREE <u></u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   |   | 22c. DATE SIGNED <u>11/19/87</u>  |   |  |  |
| 22d. PHYSICIAN'S NAME (Type) <u>GERARD CHURCH, M.D.</u>  |  |   | 22e. ADDRESS <u>EVERGREEN AT RIGGS AVENUE</u>  |   |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  |   | 23b. DATE <u>Nov. 20. 1987</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY <u>Geary Washington Cemetery</u> |   | 23d. LOCATION (City or Town) <u>Alexandria</u> (County) <u>IND.</u>               |  |  |
| 24. FUNERAL DIRECTOR <u>Takoma Funeral Home 940 N. 1st St. 254</u>   |  |   | ADDRESS <u>254</u>   |   |   | 25. ISSUED BY REGISTRAR <u>NOV 23 1987</u>  |   | 25a. REGISTRAR'S SIGNATURE <u>Charles J. Van Natten</u>              |  |

*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to see the deceased.

DHMH - 16 50M 1/81  
(VRA 15, 4)

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

81

27962

EST

REG. NO.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MILDRED LUCRETIA ROBINETTE</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 17 1981</b>                                  |  | 2b. HOUR A<br><b>3:25 M</b>                                      |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 23, 1932</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>49</b> YRS.                                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD.</b>                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>             |
| 13a. STATE<br><b>Maryland</b>   | 13b. COUNTY<br><b>A.A.</b>   | 13c. CITY OR TOWN<br><b>Glen Burnie</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>51 Mapledale Ave.</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Walter R. Price</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Macie V. Harper</b>                         |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217.28.0004</b>  |   | 17. INFORMANT (Husband) ADDRESS<br><b>Mr. Charles F. Robinette</b> Same as # <b>13</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac arrest</b><br><b>4275</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>              |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Marc Kaplan</b>  |  |   |   | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARC KAPLAN</b>   |  |   |   | 22e. ADDRESS<br><b>7845 OAKWOOD ROAD #200<br/>GLEN BURNIE, MARYLAND 21061</b>          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>20 Nov. 81</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lake View Mem. Pk.</b>                        |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Sykesville, Carroll, MD.</b>   |  | 23e. DATE REC'D. BY REGISTRAR<br><b>NOV 19 1981</b>   |   | 23f. REGISTRAR'S SIGNATURE<br><b>James J. Nathan</b>                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>H.B. Umans</b> <b>Glen Burnie, MD.</b><br><b>Singleton Funeral Home</b>  |  |   |   |  |  |

BP

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 9 6 3

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |  |  |  |
|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Andrew Elmer Robinson - Sr.</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 29, 1981</b>  |  | 2b. HOUR<br><b>11:06 PM</b>  |
| 3. SEX<br><b>MALE</b>  | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 20, 1905</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>MD.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL CO. MD.</b>                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Annapolis</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ANNE ARUNDEL GENERAL HOSP</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Carpenter</b>                         | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Govt.</b>                               |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MD.</b>   | 13b. COUNTY<br><b>AA</b>  | 13c. CITY OR TOWN<br><b>Annapolis</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>              | 13e. STREET ADDRESS<br><b>5 School St.</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Andrew Leonard Robinson</b>   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Magdaline Jackson</b>   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NAME UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b> |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>215-24-7324</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Mrs. D. Estelle Brown 8 Hill St. Annapolis, Md.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>4140</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Myocardial Infarction</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Hours</b> |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/31 1965</b> to <b>11/29 1981</b> , that (I) (we) lost saw the deceased alive on <b>11/20 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) view the body after death.  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>R. I. Hochman</b>   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>11/30/81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. I. Hochman, MD</b>  |   | 22e. ADDRESS<br><b>16 Murray Ave, Annapolis, Md 21401</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   | 23b. DATE<br><b>12/3/81</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Annapolis AA MD.</b>                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Taylor Funeral Chapel</b>   |   | ADDRESS<br><b>Annapolis MD</b>  |  | 25. DATE REC'D. BY REGISTRAR<br><b>DEC 2 1981</b>                                    |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



Amelia Anne Lewis (nee) Hays Carpenter Oct 20 +  
M. A. A. A. A. A. X 21 Oct 21

Amelia Anne Lewis (nee) Hays Carpenter Oct 20 +  
M. A. A. A. A. A. X 21 Oct 21

Amelia Anne Lewis (nee) Hays Carpenter Oct 20 +  
M. A. A. A. A. A. X 21 Oct 21

Amelia Anne Lewis (nee) Hays Carpenter Oct 20 +  
M. A. A. A. A. A. X 21 Oct 21

#2a,c, Film G561

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR 11/30/81 kam  
STATE REGISTRAR

|   |  |                  |  |   |  |   |  |   |   |  |  |   |  |  |
|---|--|------------------|--|---|--|---|--|---|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>William Aloysius Rodgers   |  |                  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH 20 DAY 11 YEAR 1981<br>MATED <input type="checkbox"/> MONTH 11 DAY 19 YEAR 81 |   |  | 2b. HOUR<br>P M   |  |   |   |  |  |   |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 11, 12           |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>69 YRS.   |  | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                                   |   | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>11 19 81               |  | 2d. HOUR<br>P M   |  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia   |  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel Co., MD.                                   |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Glen Burnie  |  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>North Arundel Hospital                         |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Railroad Eng.  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>B & O R.R.   |  |  |   |  |  |
| 13a. STATE<br>Maryland  |  |                  | 13b. COUNTY<br>Anne Arundel  |   |  | 13c. CITY OR TOWN<br>Glen Burnie  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET ADDRESS<br>307 Burwood Avenue   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John F. Rodgers   |  |                  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Genevieve Riordan   |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |  |   | 16b. SOCIAL SECURITY NO.<br>N/A   |  |  | 17. INFORMANT (Wife) ADDRESS<br>Mrs. Alma R. Rodgers # 13                           |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Chronic obstructive pulmonary disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |  |                  |  |   |  |   |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 year</u>                       |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).   |  |                  |  |   |  |   |  |   |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |   |  |   |   |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  |   |  | 21f. LOCATION<br>STREET   |   | CITY OR TOWN   |  | COUNTY STATE  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |   |  |   |   |  |  |   |  |  |
| ACTUAL SIGNATURE<br><u>E. Linhardt MD</u>   |  |                  |  | TITLE (SPECIFY)<br>M.D. <u>Deputy</u>                       |  |   |  | MEDICAL EXAMINER  |   |  |  | DATE SIGNED<br>11-29-81   |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>E. LINHARDT MD  |  |                  |  | ADDRESS<br><u>Annapolis, Md</u>                             |  |   |  |   |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |                  |  | 23b. DATE<br>23 Nov. 81                                     |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem. Pk.   |  |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Glen Burnie, A.A., MD. |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>H. B. Vician</u>   |  |                  |  | Glen Burnie, MD.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 23 1981                                  |   |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>James J. Nathan</u>                                |  |  |

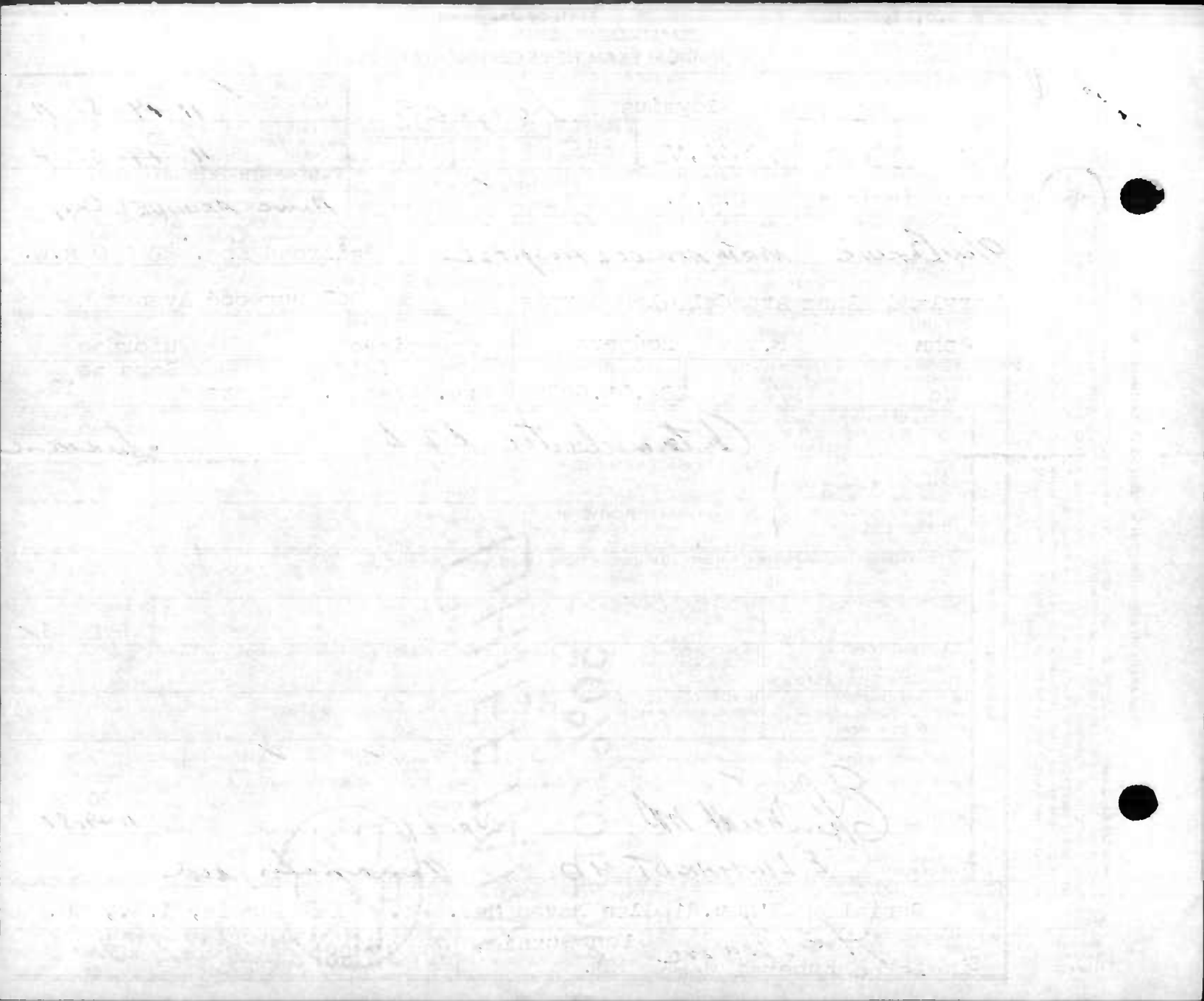
MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH-17  
(VR A15 ME (5))  
15M 7/77



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 9 6 5

1- FOR  
STATE  
REGISTRAR

REG. NO.

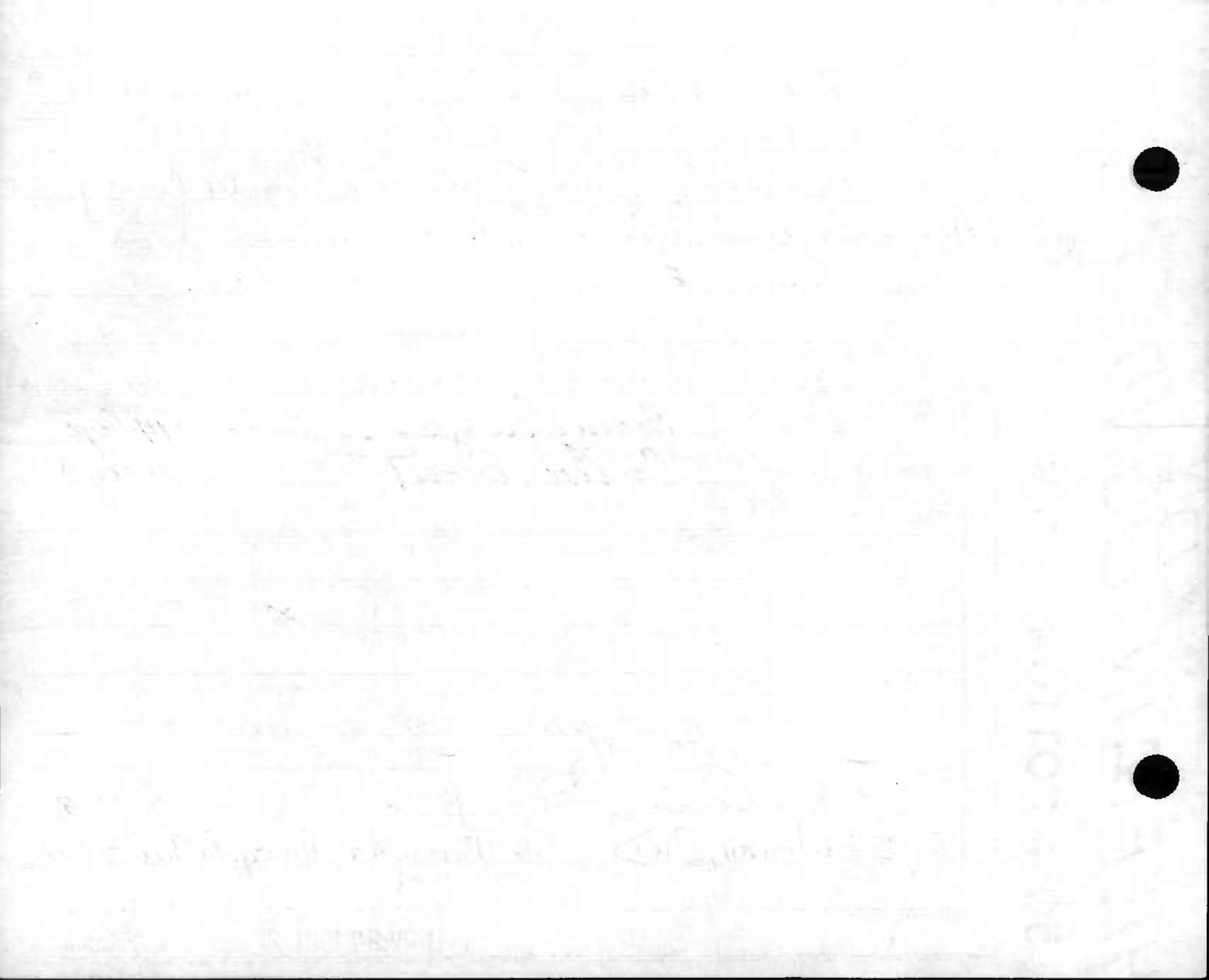
|   |                 |  |   |  |   |
|---|-----------------|--|---|--|---|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Robert Edsel Roe   |                 |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>11 25 81            |  | 2b HOUR<br>11 A M   |
| 3 SEX<br>Male   | 4 RACE<br>White | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>4 30 1906   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>75   | 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Bernardsville, N.J. USA   |
| 7b CITIZEN OF WHAT COUNTRY?<br>USA  |                 | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel County MD  |   |
| 10 CITY OR TOWN OF DEATH<br>Annapolis   |                 | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Anne Arundel Gen. Hosp.                        |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>consultant                                    | 12b KIND OF BUSINESS OR INDUSTRY<br>tax   |
| 13a STATE<br>Md.  |                 | 13b COUNTY<br>A.A.Co.  | 13c CITY OR TOWN<br>Edgewater                             | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   | 13e STREET ADDRESS<br>3879 Cotter Dr.   |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Edward   |                 | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Jeanette Nunn  |   | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>yes 1942-1943 |   |
| 16b SOCIAL SECURITY NO.<br>228-30-2815  |                 | 17 INFORMANT<br>Richard R. Roe   |   | ADDRESS<br>3879 Cotter Dr. Edgewater Md.   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Brain damage</u><br>4375 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Cardiac Arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u>   |                 |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>14 days<br>14 days  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>  |                 |  |   |  |   |
| 19a DATE OF OPERATION   |                 | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                              | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                 | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                                    |   |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                 | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a I certify that (I) (this hospital) attended the deceased from <u>4/27</u> 19 <u>71</u> to <u>11/25</u> 19 <u>81</u> , that (I) <del>was</del> last saw the deceased alive on <u>11/25</u> 19 <u>81</u> , and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>do not</del> view the body after death. |                 |  |   |  |   |
| 22b SIGNATURE<br>R. I. Hochman, M.D.  |                 | DEGREE   |   | 22c DATE SIGNED<br>11/25/81  |   |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>R. I. Hochman, M.D.   |                 | 22e ADDRESS<br>16 Murray Ave Annapolis, Md. 21402  |   |  |   |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |                 | 23b DATE<br>11/30/81   | 23c NAME OF CEMETERY OR CREMATORY<br>Md Veterans Cemetery |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Crownsville, Md.   |
| 24 FUNERAL DIRECTOR<br>NAME<br>Hardesty Funeral Home 12 Ridgely Ave. Ann. Md.   |                 | ADDRESS  |   | 25a DATE REC'D. BY REGISTRAR<br>NOV 27 1981  |   |
|   |                 |  |   | 25b REGISTRAR'S SIGNATURE<br>James VanNathan   |   |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 9 6 6

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |                           |   |   |   |  |
|---|--|--|--|---|---------------------------|---|---|---|--|
| 2. DECEASED NAME<br>(TYPE OR PRINT)<br>ELMA Eula ROSEWELL |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 6, 1981        |   |                           | 2b. HOUR<br>11:45 P.M.  |   |   |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>MAY 12, 1912  |                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br>69 YRS   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>W. Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ANNE ARUNDEL MD.  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>BROOKLYN PARK                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>HAMMONDS LANE NRSG CTR. |  |   |                           | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker                             |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home                   |  |
| 13a. STATE<br>Maryland                                    |  |  | 13b. COUNTY<br>AnneArundel                                     |   | 13c. CITY OR TOWN<br>Park |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Goff Lewis      |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Nellie Linger |   |                           | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No N/A |   |   |  |
| 17. INFORMANT<br>Mr. Howard L. Rosewell (son)             |  |  | 18. SOCIAL SECURITY NO.<br>235-05-8460                         |   |                           | 19. ADDRESS<br>Same as # 13   |   |   |  |

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|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CardioPulmonary Arrest</u><br>2500<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Dilated</u><br>(c) <u>DUE TO, OR AS A CONSEQUENCE OF</u> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|--|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  
Chronic Renal Failure with secondary anemia. Left eye - exsurgin cataract.

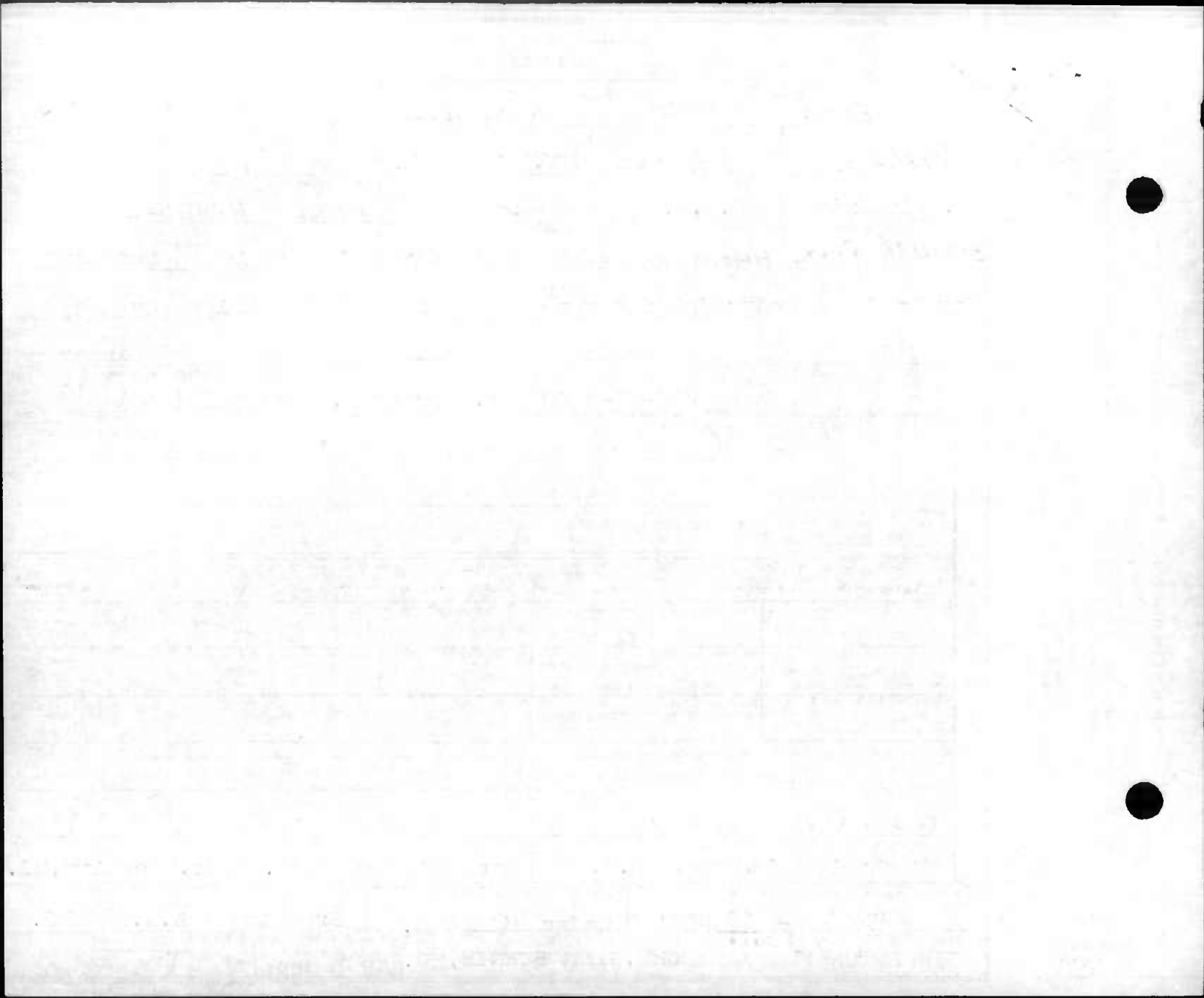
|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |

22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that (I) (we) lost  
saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

|   |  |  |  |                             |  |
|---|--|--|--|-----------------------------|--|
| 22b. SIGNATURE<br><u>Michael Schwartz M.D.</u>                  |  | DEGREE   |  | 22c. DATE SIGNED<br>11/7/81 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Michael Schwartz, M.D. |  | 22e. ADDRESS<br>Hammonds Lane Med. Cntr. Brooklyn, Md. |  |                             |  |

|  |  |                         |  |   |  |   |  |
|--|--|-------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                   |  | 23b. DATE<br>10 NOV '81 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cem. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brooklyn A.A. Md. |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SINGLETON FUNERAL HOME, GLEN BURNIE, MD. |  |                         |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 9 1981           |  | 25b. REGISTRAR'S SIGNATURE<br><u>Thomas J. K. K...</u>          |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 9 6 7

REG. NO.

|  |  |  |  |  |                                   |  |
|--|--|--|--|--|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Giovanni G. Sartorelli</i>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>11-25-81</i> |  | 2b. HOUR<br>MIN.<br><i>9:50 A</i> |  |
| 3. SEX<br><i>Male</i>  |  | 4. RACE<br><i>White</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>7-24-94</i>   |                                   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>87</i> YRS.  |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Italy</i>   |  | 8. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |                                   |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Anne Arundel</i> MD.  |  | 10. CITY OR TOWN OF DEATH<br><i>Annapolis</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Anne Arundel Gen. Hosp.</i>  |                                   |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Maintenance</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Pulp Mill</i>  |  | 13a. STATE<br><i>MD.</i>   |                                   |  |
| 13b. COUNTY<br><i>A.A.</i>   |  | 13c. CITY OR TOWN<br><i>Millersville</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Unknown</i>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Unknown</i>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |                                   |  |
| 16b. SOCIAL SECURITY NO.<br><i>008-07-6697</i>   |  | 17. INFORMANT<br>NAME ADDRESS<br><i>Mary Caspari Sec. 13</i>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma of Prostate</i><br>1850<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) |  |  |  |  |                                   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>           |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>  |                                   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I; OR PART 2)  |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><i>July 75</i>   |                                   |  |
| 21f. LOCATION<br>(CITY OR TOWN, COUNTY, STATE)<br><i>Baltimore City MD.</i>  |  | 22a. I certify that (this hospital) attended the deceased from <i>July 75</i> , 19 <i>75</i> , to <i>11-25-81</i> , 19 <i>81</i> , and that in my (my) opinion death occurred on the date and hour and from the causes stated above. (If I did not view the body after death, so, the deceased alive on <i>11-25-81</i> , and that in my (my) opinion death occurred on the date and hour and from the causes stated above.) |  | 22b. SIGNATURE<br><i>Arnold G. Alexander</i> MD.<br>DEGREE   |                                   |  |
| 22c. DATE SIGNED<br><i>11-25-81</i>  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Arnold G. Alexander</i>  |  | 22e. ADDRESS<br><i>650 Ritchie Hwy Severna Park MD</i>   |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIES<br><i>Burial</i>  |  | 23b. DATE<br><i>11-28-81</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>New Cathedral</i>   |                                   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore City MD.</i>  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Robert S. Barranco Severna Park MD</i>  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 30 1981</i>  |                                   |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |  |  |                                   |  |

BP.

PA

*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 9 6 8

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |                             |  |   |   |   |
|--|-----------------------------|--|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ELIZABETH Thomas SCHUMACHER</b>               |                             |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-23-81</b>                          |   | 2b. HOUR<br><b>6:30 P</b>   |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>CAUCASIAN</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12-13-95</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Annapolis</b>                        |                             | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 10. CITY OR TOWN OF DEATH<br><b>Annapolis</b>  |                             | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Anne Arundel General</b> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel</b> MD.   |   |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |                             | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>   |   |   |   |
| 13a. STATE<br><b>MD</b>  |                             |  | 13b. COUNTY<br><b>A.A.</b>  | 13c. CITY OR TOWN<br><b>Annapolis</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William H. Thomas</b>                   |                             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Daisy Elizabeth Hubbard</b> |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>    |                             | 16b. SOCIAL SECURITY NO.<br><b>220-38-0920</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>624 Beach Drive<br/>Annapolis, MD</b>  |   |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c):<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Acute Renal Failure</b><br><b>0381</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Staphylococcal septicemia</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Shock</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

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| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Rheumatoid Arthritis</b>  |  |  |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><b>J. Lieberstein</b>   |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jack Lieberstein</b>  |  | 22e. ADDRESS<br><b>Annapolis, Maryland</b>   |  |

|   |                                 |  |  |
|---|---------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                       | 23b. DATE<br><b>Nov 25 1981</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>U.S. Naval Academy</b>                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Annapolis A.A. MD</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Taylor Funeral Chapel, Annapolis, MD</b> |                                 | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>NOV 27 1981</b> |  |



James H. Arnold

X

James H. Arnold

James H. Arnold

James H. Arnold

James H. Arnold

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DHMH-16 30M 2/80  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |   |                                   | REG. NO. 8127969   |  |
|--|--|---|--|---|--|--|--|---|-----------------------------------|--|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Pietrina C. Sciacca</i>  |  |   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>11-9-81</i>                         |                                   | 2b. HOUR<br><i>9:00 A.</i>   |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>8-28-1892</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>89</i> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.              |                                   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Balto. Md.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Anne Arundel Co., MD.</i>   |  |   |                                   |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Riviera Beach</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>173 Meadow Road</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Homemaker</i>   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| 13a. STATE<br><i>Md.</i>   |  |   |  |   |  | 13b. COUNTY<br><i>Anne Arundel</i>   |  | 13c. CITY OR TOWN<br><i>Riviera Beach</i>                                     |                                   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Angelo Glorioso</i>   |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Concetta Jeppi</i>   |  |   |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>213-74-8097</i>   |  | 17. INFORMANT<br>ADDRESS<br><i>Mr. Rosario C.A. Glorioso -4404 LaSalle Ave. 21206</i>   |  |  |  |   |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>ACUTE MYOCARDIAL INFARCTION</i><br>4100<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>HYPERTENSION</i><br>(c) <i>15 YRS</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>SUDDEN</i> |  |   |  |   |  |  |  |   |                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |   |                                   |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |                                   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |                                   |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>3-25</i> , 19 <i>68</i> , to <i>1-6</i> , 19 <i>81</i> , that (I) (we) lost saw the deceased alive on <i>1-6</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) (did not) view the body after death.   |  |   |  |   |  |  |  |   |                                   |  |  |
| 22b. SIGNATURE<br><i>Arthur Lankford Jr. M.D.</i>  |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>11-10-81</i>   |                                   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>ARTHUR LANKFORD, JR., M. D.</i>  |  |   |  |   |  | 22e. ADDRESS<br><i>2934 Mt. Rd. Pasadena, MD. 21122</i>  |  |   |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Entombment</i>   |  |   |  | 23b. DATE<br><i>11-13-81</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Dulaney Valley Cem.</i>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Cockeysville Md.</i>         |                                   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>John C. Miller Inc-6415 Belair Rd.-21206</i>  |  |   |  |   |  | ADDRESS<br><i>21206</i>  |  | 25. DATE REC'D BY REGISTRAR (15 REGISTRATION SIGNATURE)<br><i>NOV 16 1981</i> |                                   |  |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 1b g561 11/23/81 gj

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 8127970  |  | E.S.T.   |  |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 1. DECEASED NAME  |  | 2a. DATE OF DEATH  |  |
|   |  |  |  | FIRST MIDDLE LAST   |  | MONTH DAY YEAR HOUR  |  |
| LILLIAN M SEIFARTH  |  |  |  | NOVEMBER 8, 1981  |  | 3:00PM   |  |
| 3 SEX   |  | 4 RACE   |  | 5. DATE OF BIRTH  |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                 |  |
| Female  |  | white  |  | MONTH DAY YEAR  |  | IF UNDER 1 YEAR MONTHS DAYS                                    |  |
| Jan. 17 1894  |  |  |  | 87 YRS.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                            |  |
| Maryland  |  | U.S.A.   |  |   |  | ANNE ARUNDEL COUNTY MD.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| GLEN BURNIE   |  | NORTH ARUNDEL HOSPITAL   |  | housewife   |  |  |  |
| 13a. STATE  |  |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  |
| Maryland  |  |  |  | Allegany  |  | Claysville   |  |
| 14. FATHER'S NAME   |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |
| FIRST MIDDLE LAST   |  |  |  | FIRST MIDDLE LAST   |  |  |  |
| George Engle  |  |  |  | Sophia Rephann  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |  |
| No  |  |  |  | 214-46-2893   |  | Earl Seifarth Route 3, Claysville                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |  |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>   |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic breast carcinoma</u>   |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic cardiovascular disease</u>   |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>1749</u>  |  |  |  |   |  |  |  |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
| 2.3 months (2)  |  | Surgery for breast cancer  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
|   |  | P.M. 19  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
|   |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct-9</u> , 19 <u>81</u> , to <u>Nov-8</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>Nov-8</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE  |  |  |  | DEGREE  |  | 22c. DATE SIGNED   |  |
| <u>Ira E. Kaplan, MD</u>  |  |  |  |   |  | <u>11/8/81</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS  |  |  |  |
| IRA E. KAPLAN, M.D.   |  |  |  | 7845 OAKWOOD ROAD, #200<br>GLEN BURNIE, MARYLAND 21061  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |
| Burial  |  | Nov. 11, 1981  |  | Sunset Memorial Park  |  | Cumberland Allegany Md   |  |
| 24. FUNERAL DIRECTOR  |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                                     |  |
| Durst Funeral Home 57 Frost Avenue<br>Frostburg, Maryland 21532   |  |  |  | NOV 16 1981   |  | <u>James J. Parthen</u>  |  |

27

Jan. 17, 1981

State

Ohio

x

County

Hamilton

Hamilton, Ohio

x

Hamilton

County

Ohio

Hamilton

County

Ohio

County

Hamilton, Ohio

Ohio

Nov. 11, 1981

State

Nov. 11, 1981

County

Nov. 11, 1981

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

81 27971

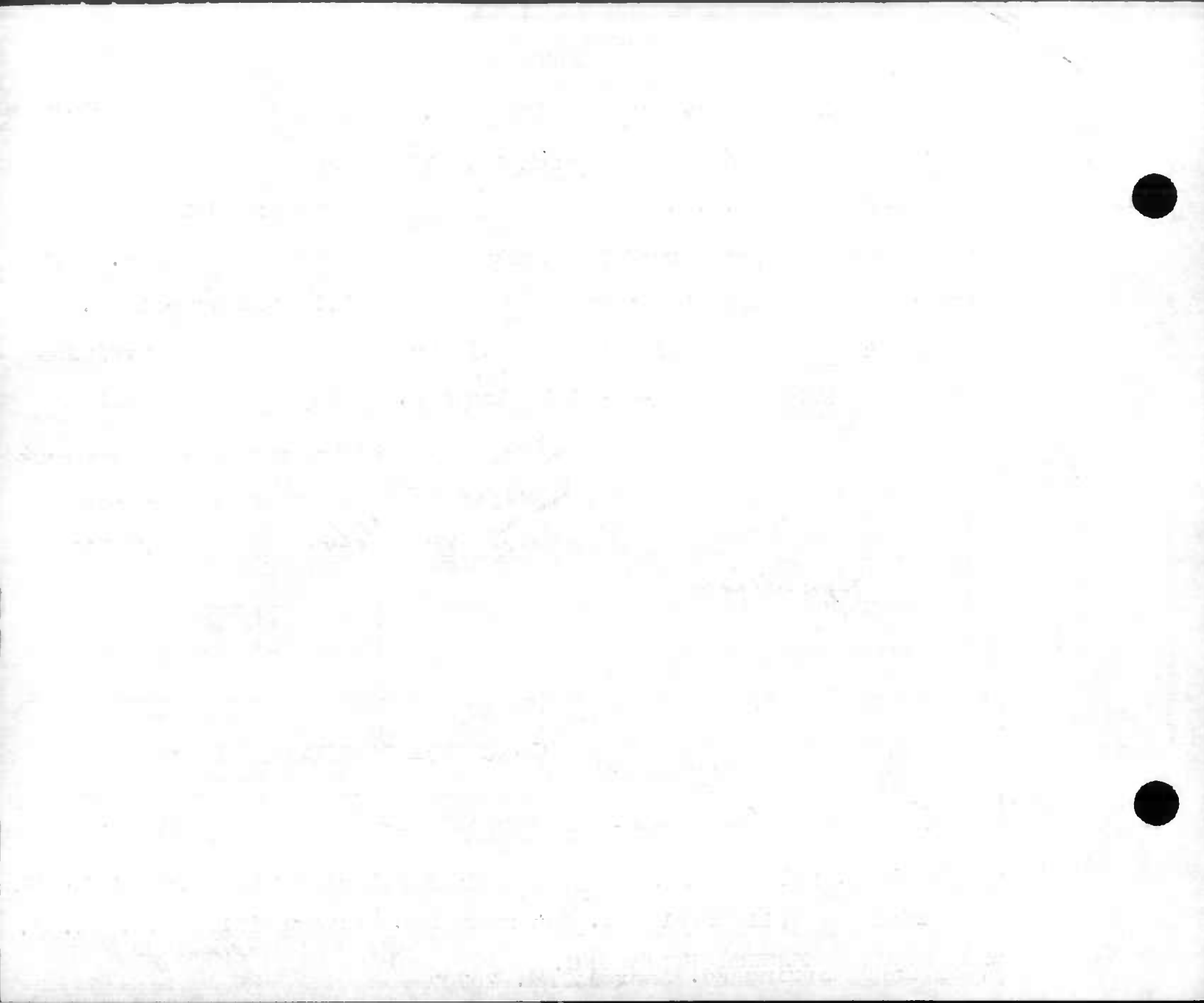
REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>William Frederick Sibley Sr.  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 23, 1981                  |   | 2b. HOUR<br>5 am.  |
| 3. SEX<br>Male   | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>March 10, 1915  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Glen Bernie   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>North Arundel Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Guard | 12b. KIND OF BUSINESS OR INDUSTRY<br>Dept. Navy   |  |
| 13a. STATE<br>Maryland   |   | 13b. COUNTY<br>Anne Arundel   | 13c. CITY OR TOWN<br>Laurel   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET ADDRESS<br>332 Vale Summit So.   |   |   |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Kenneth Sibley   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Violet Parkinson         |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII   |   | 17. INFORMANT<br>Gladys E. Sibley same as #13   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Coronary Heart Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>generalized atherosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Diabetes mellitus</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3500</u> years<br><u>years</u> |   |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Hypertension</u>   |   |   |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan. 1972</u> to <u>Nov. 23, 1981</u> , that (I) (we) last saw the deceased alive on <u>Nov. 16, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |   |   |  |
| 22b. SIGNATURE<br><u>David M. Goldman</u>  |   | DEGREE<br>M.D.  |   | 22c. DATE SIGNED<br>11/23/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>David M. Goldman M.D.   |   | 22e. ADDRESS<br>6525 Belcrest Rd. Hyattsville Md.   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   | 23b. DATE<br>11/25/81   | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. Veterans Cem.   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Crownsville, A.A. Co. Md.   |   |  |
| 24. FUNERAL DIRECTOR<br>FLECK LAUREL FUNERAL HOME, INC.<br>7601 Sandy Spring Rd. Laurel, Md. 20707   |   |   | 25a. DATE SIGNED BY REGISTRAR<br>NOV 27 1981                              |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE REGISTRAR

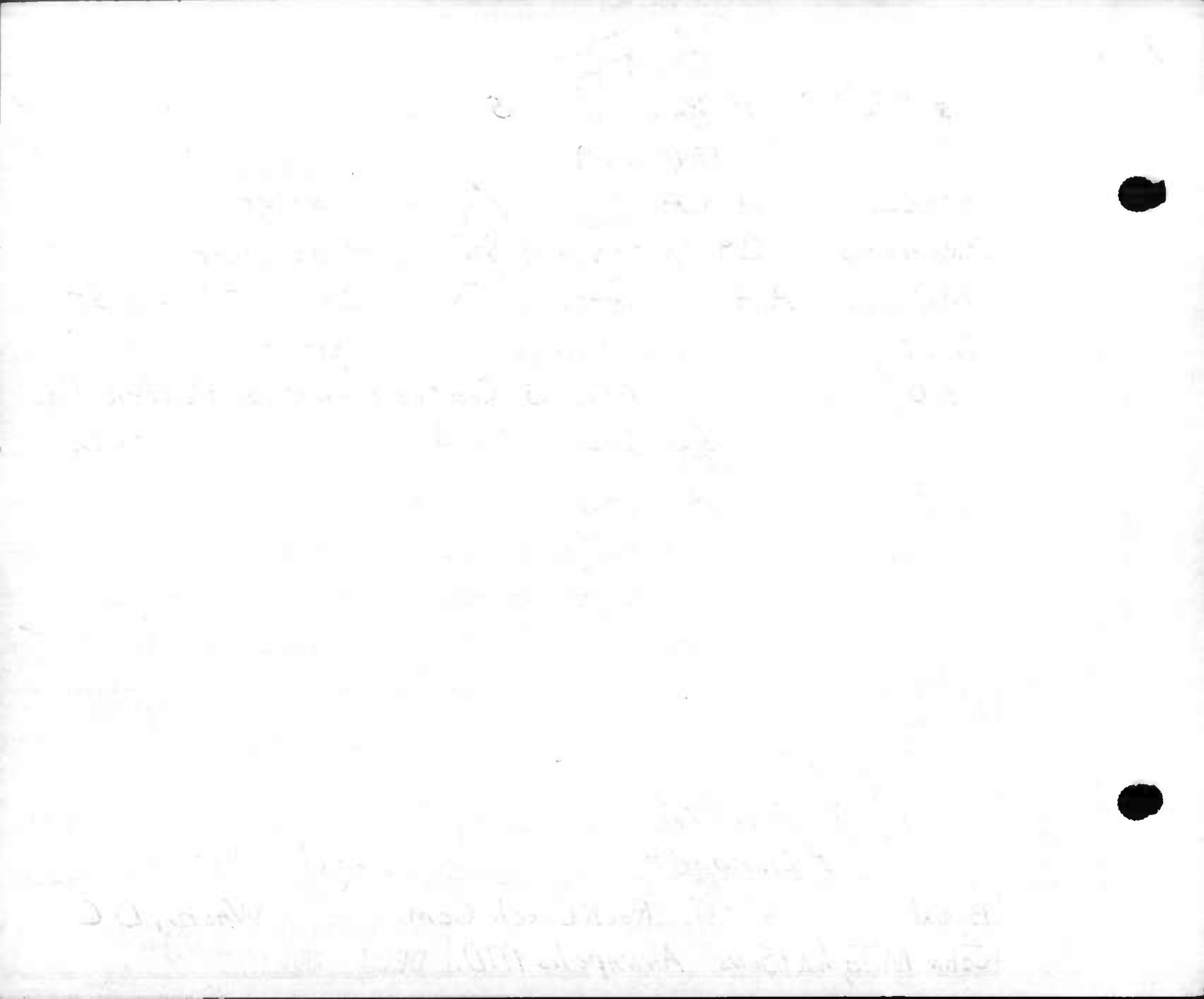
|  |                             |  |   |   |
|--|-----------------------------|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Despina BAKALIS SKOUZES</b>   |                             | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br><b>11 29 81</b>   |   | 2b. HOUR<br><b>A</b>  |
| 3. SEX<br><b>F</b>   | 4. RACE<br><b>W</b>         | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 17, 1902</b>   | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br><b>79</b> YRS.                        | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Greece</b>   |                             | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH<br><b>Annapolis</b>  |                             | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>29 West Wash. St.</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |
| 13a. STATE<br><b>MD.</b>   |                             | 13b. COUNTY<br><b>A.A.</b>   | 13c. CITY OR TOWN<br><b>Annapolis</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Nick Kounoulos</b>  |                             | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Chrysoula HATH Platos</b>  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>   |                             | 16b. SOCIAL SECURITY NO.<br><b>577-54-3115</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Cristine Samaras 155 Porter Dr.</b>  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>4029</b> IMMEDIATE CAUSE <b>Myocardial Infarction</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                             |  |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>As a consequence of</b>  |                             |  |   |   |
| 19a. DATE OF OPERATION   |                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                             | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   |   |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                             |  |   |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                             |  |   |   |
| ACTUAL SIGNATURE<br><b>E. L. Hubbard</b>   |                             | TITLE (SPECIFY)<br>M.D. <b>Deputy</b>  |   | DATE SIGNED<br><b>11.29.81</b>  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>E. L. Hubbard</b>   |                             | ADDRESS<br><b>Annapolis</b>  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>12/2/81</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rock Creek Cem.</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Wash., D.C.</b>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John M. Taylor &amp; Sons</b>   |                             | ADDRESS<br><b>Annapolis MD.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 1 1981</b>  |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M2/80



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 9 7 3

|   |  |   |  |
|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>ANNIE V SMITH   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>NOV. 18, 1981   |  |
| 3. SEX<br>FEMALE  |  | 2b. HOUR<br>12:45 P.  |  |
| 4. RACE<br>BLACK  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>99 YRS.  |  |
| 5. DATE OF BIRTH MONTH DAY YEAR<br>12 13 81   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ANNE ARUNDEL MD.  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>LAUNDRESS  |  |
| 10. CITY OR TOWN OF DEATH<br>ANNAPOLIS  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BAY MANOR NURSING HOME  |  |   |  |
| 13a. STATE<br>MARYLAND  |  | 13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 13c. CITY OR TOWN<br>Calvert  |  | 13d. STREET ADDRESS<br>RT. 1, Box 75  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>John Smith   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Matilda Morsell   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>----  |  |
| 17. INFORMANT ADDRESS<br>Theo R. Foote 3440 25th St. S.E. Wash., D.C.   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Respiratory Arrest.<br>4140 DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory Failure<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) Chronic Ischemic Heart Disease |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/4/81 to 11/18/81, that (I) (we) last saw the deceased alive on 11/11/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |
| 22b. SIGNATURE<br>[Signature]   |  | 22c. DATE SIGNED<br>11/18/81  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. C. V. CYRIAC   |  | 22e. ADDRESS<br>7445-A FURNACE BR-RD GLENBURNIE MD 21061  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>Nov. 21-81   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Olive Chr. Cem  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Prince Frederick Calvert Md.   |  |
| 24. FUNERAL DIRECTOR NAME<br>Spencer E. Sewell  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 23 1981  |  |
| ADDRESS<br>Box 31, Prince Frederick, Md.  |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |

BP

Director, Federal Bureau of Investigation  
Washington, D.C. 20535

DR. C. V. CURTIS

✓  
THAT A FURNACE  
COLUMBIA MO 20061

11/18/21  
11/18/21  
11/18/21

Return letter to Bureau  
Regarding letter  
Regarding letter

TO  
FROM  
SUBJECT

RE: [illegible]  
[illegible]  
[illegible]

DATE  
TIME  
PLACE

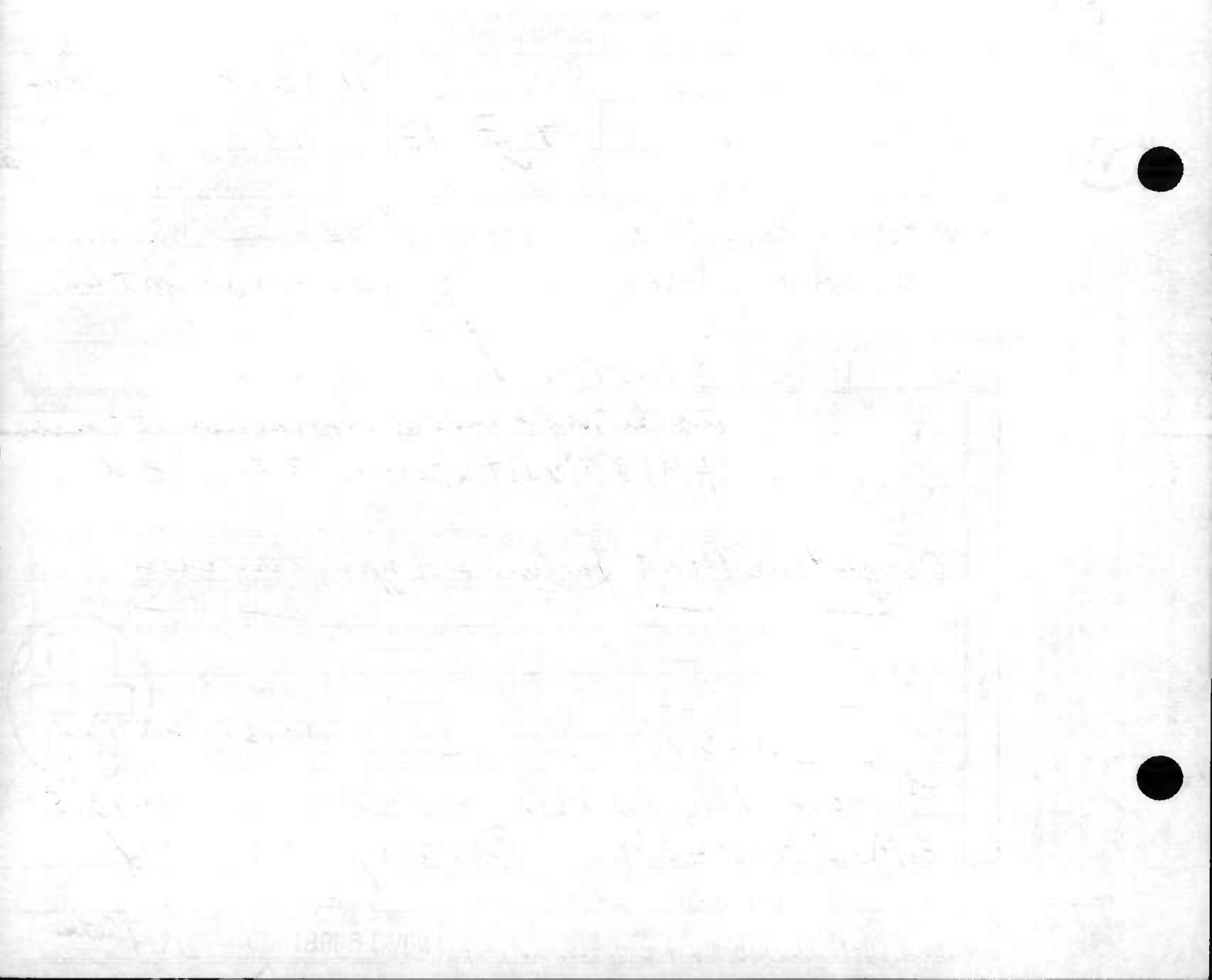
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 9 7 4

15 +1  
1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |                          |  |
|---|--|--|--|---|--------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HYMAN W. SNYDER</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-13-81</b> |   | 2b. HOUR<br><b>20:04</b> |  |
| 3 SEX<br><b>MALE</b>  |  | 4 RACE<br><b>1</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7-3-13</b>   |                          |  |
| 6a. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.   |                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Annapolis</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                          |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel Co.</b>   |  | MD.  |  |   |                          |  |
| 10. CITY OR TOWN OF DEATH<br><b>ANNAPOLIS</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ANNE ARUNDEL GENERAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CLERK</b>  |                          |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>POST OFFICE</b>   |  |  |  |   |                          |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>AA</b>   |  | 13c. CITY OR TOWN<br><b>ANNAPOLIS</b>   |                          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Max Snyder</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mollie Finglass</b>  |  |   |                          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>1941-2</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Rhea Snyder, Annapolis, Md.</b>  |                          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>AMI + arrest + Resuscitation</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <b>8 d.</b> |  |  |  |   |                          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Congestive Heart Failure + Hypertension</b>  |  |  |  |   |                          |  |
| 19a. DATE OF OPERATION<br><b>11-13-81</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>AMI</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                          |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |   |                          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-13-81</b> , 19 <b>81</b> , to <b>11-13-81</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>11-13-81</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |                          |  |
| 22b. SIGNATURE<br><b>Frank M Shipley M.D.</b>   |  | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>11-13-81</b>   |                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>F.M. SHIPLEY</b>  |  | 22e. ADDRESS<br><b>Annapolis, Md</b>   |  |   |                          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11-15-81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Kneseth Israel</b>   |                          |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Annapolis AACo Md</b>  |  |  |  |   |                          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hardesty FH, 12 Ridgely Ave, Annapolis, Md. 21401</b>  |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 16 1981</b>   |                          |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Thomas J. Nathan</b>   |                          |  |



BP

DHMH-16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 8 1 2 7 9 7 5<br>REG. NO.   |  | E.S.T.  |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>JOSEPHINE A. SOJKA  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>NOVEMBER 6, 1981  |  | 2b. HOUR A.M.<br>3:00   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Feb. 18, 1895  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br>86  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Poland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ANNE ARUNDEL COUNTY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>GLEN BURNIE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NORTH ARUNDEL HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MD 13b. COUNTY AA 13c. CITY OR TOWN Glen Burnie 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 619 Greenway, S.E.   |  |  |  |   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Joseph Wasowicz   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Anna NA   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>213-09-9557  |  | 17. INFORMANT ADDRESS<br>Frank A. Phillips, 636 Glen Burnie, MD<br>Baylor Rd.   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>pneumonia (aspiration)</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>GI bleeding</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>loss of peptic ulcer disease</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Hypertension ASCVD CHF</u> |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 1, 1981</u> to <u>11-6-81</u> , that (I) (we) lost saw the deceased alive on <u>11-5-81</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |
| 22b. SIGNATURE <u>Mustafa C. Oz, M.D.</u> DEGREE <u>MD</u>   |  |  |  | 22c. DATE SIGNED <u>11-6-81</u>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MUSTAFA C. OZ, M.D.   |  |
| 22e. ADDRESS 605 BALTIMORE-ANNAPOLIS BOULEVARD SEVERNA PARK, MARYLAND 21146  |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>Nov. 9, 81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Stanislaus  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore MD   |  |
| 24. FUNERAL DIRECTOR NAME<br>James S. Kirkley, Glen Burnie, MD   |  |  |  | 25a. DATE REC'D. BY REGISTRAR 10 1981 REGISTRAR SIGNATURE <u>James S. Kirkley</u>   |  |   |  |

James H. Harkley, from Baltimore, Md.

Nov. 1, 1881

My dear Sir,

I have the honor to acknowledge the receipt of your letter of the 29th inst.

and in reply to inform you that the same has been forwarded to the proper authorities.

I am, Sir, very respectfully,  
Yours,  
J. H. Harkley

(Signature)

By J. H. Harkley, Esq.

Attorney at Law

Baltimore, Md.

(Signature)

By J. H. Harkley, Esq.

Attorney at Law

Baltimore, Md.

(Signature)

By J. H. Harkley, Esq.

Attorney at Law

Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be buried within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 81 27976  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Vernon A. Sparks   |  |  |  | 2b. HOUR<br>P. M.  |  |  |  |
| 3 SEX<br>male  |  | 4 RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>June 3, 1920  |  | 6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br>61  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel MD.  |  |
| 10 CITY OR TOWN OF DEATH<br>Annapolis  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Anne Arundel General |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Millman   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Lumber Co.  |  |
| 13a. STATE<br>MD   |  |  |  | 13b. COUNTY<br>AA  |  | 13c. CITY OR TOWN<br>Annapolis   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>Alfred Sparks  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Ruth Kelley  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  |  |  | 16b. SOCIAL SECURITY NO.<br>218-09-0756  |  | 17. INFORMANT ADDRESS<br>Nora Beatrice Sparks<br>Same as #13   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4149 Coronary Artery Disease<br>DUE TO, OR AS A CONSEQUENCE OF (b) Sudden<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1969, 19, to 11-20-81, 19, that (I) (we) last saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>E. L. Hubert Jr. MD  |  |  |  | 22c. DEGREE<br>MD  |  | 22d. DATE SIGNED<br>11-21-81   |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br>E. L. Hubert Jr. MD   |  |  |  | 22f. ADDRESS<br>Annapolis MD   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>Nov 23, 1981  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Stevensville   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Stevensville Q.A. MD  |  |
| 24 FUNERAL DIRECTOR NAME<br>Taylor Funeral Chapel, Annapolis, MD   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 24 1981   |  |  |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Anne J. [Signature]  |  |  |  |

BP \_\_\_\_\_



Item 16b g562 12/9/81 g1  
FOR  
1- STATE REGISTRAR Item 2a g562 12/11/81 g2  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
REG. NO. 27977

|  |                  |  |  |   |   |
|--|------------------|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>IRWIN SPURLOCK  |                  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED MONTH DAY YEAR<br>10 12 14 81 |   | 2b. HOUR<br>M<br>11 30 AM   |
| 3. SEX<br>male   | 4. RACE<br>black | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jun 25, 1905   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS<br>76                       | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.   | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>11-11-81                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>La.   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 10. CITY OR TOWN OF DEATH<br>Md.   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Plaza Manor Nursing Home |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel County MD  |   |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired   |                  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Unknown                       |   |   |
| 13a. STATE<br>Md.  |                  |  | 13b. CITY OR TOWN<br>Landover                                      | 13c. STREET ADDRESS<br>3239 75th Avenue   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Dock Spurlock  |                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Unknown           |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |                  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>433-03-1339   |  | 17. INFORMANT ADDRESS<br>Mrs. Ethel M. Spurlock/wife/same as 13c  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last   |                  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                  |  |  |   |   |
| 19a. DATE OF OPERATION   |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |  |  |   |   |
| ACTUAL SIGNATURE<br><u>Margarita A. Korell</u>   |                  | TITLE (SPECIFY)<br>M.D. Assistant  |  | DATE SIGNED<br>11-12-81   |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Margarita A. Korell, M.D.  |                  | ADDRESS<br>111 Penn Street   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |                  | 23b. DATE<br>11-14-81  | 23c. NAME OF CEMETERY OR CREMATORY<br>Harmony Memorial Pk.         |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Landover Md.                          |
| 24. FUNERAL DIRECTOR<br>NAME<br>John T. Rhines Co.,  |                  | ADDRESS<br>3015 12th St., N.E., D.C.   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 23 1981  |   |
|  |                  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Thomas Jan Nathan</u>  |   |

01

NOV 2 1981

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 9 7 8

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><del>Strohecker</del> Louis C. Strohecker   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><del>11-24</del> Nov 24 1981                      |  | 2b. HOUR<br>7:43 PM  |
| 3. SEX<br>Male   | 4. RACE<br>Caucasian   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>5 11 89   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>92 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Illinois  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Crofton   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Crofton Convalescent Center |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Inspect. Tool Making |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Civil Service   |
| 13a. STATE<br>MD.  |  | 13b. COUNTY<br>Anne Arundel   | 13c. CITY OR TOWN<br>Annapolis   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br>44 E. Lake Drive  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Herman N/A   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Emilie Thiery  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>511-46-1588   |  | 17. INFORMANT<br>SEAN E. McNeilis - 44 E. Lake Drive   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Heart Failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) General deterioration<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Sezary's Syndrome (Cutaneous Lymphoma)<br>2022<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Parkinsonism |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                             |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 17, 1980, to 11-24, 1981, that (I) (we) lost<br>saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above; (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |
| 22b. SIGNATURE<br>Oscar A. Farias, M.D.  |  |   |  | 22c. DATE SIGNED<br>11-24-81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>OSCAR A. FARIAS, M.D.   |  |   |  | 22e. ADDRESS<br>1661 Crofton Center, Crofton, MD   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>Nov. 27, 1981  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Washington National  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Suitland P.G. MD   |  | 24. FUNERAL DIRECTOR<br>NAME<br>Taylor Funeral Chapel, Annapolis, MD  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 27 1981   |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detected for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

August 1900

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

81 27979

REG. NO.

|   |  |  |   |  |                                       |
|---|--|--|---|--|---------------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Elizabeth R Sulinski  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 30 81   |  | 2b. HOUR<br>6:30 AM                   |
| 3. SEX<br>Female  | 4. RACE<br>CAUCASION   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 23 01  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS.  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 74 HRS<br>HOURS MIN.   |                                       |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>POLAND   | 7b. CITIZEN OF WHAT COUNTRY?<br>United States  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel County MD  |  |                                       |
| 10. CITY OR TOWN OF DEATH<br>Annapolis, MD  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Anne Arundel Gen. Hosp. Annapolis |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                      |  | 12b. KIND OF BUSINESS OR INDUSTRY     |
| 13a. STATE<br>MD  | 13b. COUNTY<br>Anne Arundel  | 13c. CITY OR TOWN<br>Severna Park  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                  | 13e. STREET ADDRESS<br>7 Woodward Dr.  |                                       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ADOLF SAWICKI   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>STADWICKA (in) Kowin  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO |  |                                       |
| 16b. SOCIAL SECURITY NO.<br>815-16-5705   |  | 17. INFORMANT<br>ADDRESS<br>7 Woodward Dr.   |   |  |                                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac-Pulmonary Arrest<br>2500<br>DUE TO, OR AS A CONSEQUENCE OF (b) Cor. Art. Disease<br>DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mel.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |   |  |                                       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Perianal abscess.  |  |  |   |  |                                       |
| 19a. DATE OF OPERATION<br>—   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |                                       |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  | 21g. DATE OF INJURY<br>4-29 81 11-29 81   |  |                                       |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-29 81 to 11-29 81, that (I) (we) last saw the deceased alive on 11-29 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.)                     |  |  |   |  |                                       |
| 22b. SIGNATURE<br>Gerald S. Alexander   |  | DEGREE<br>—  | 22c. DATE SIGNED<br>11-30-81  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) |
| 22e. ADDRESS  |  | 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |   |  |                                       |
| 23b. DATE<br>12-3-81  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>SACRED HEART OF FORDS BALTO  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO MD   |                                       |
| 24. FUNERAL DIRECTOR<br>NAME<br>John M. Weber & Son   |  | ADDRESS<br>4019 CHESTER  |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 4 1981  |                                       |
| 25b. REGISTRAR'S SIGNATURE<br>Anne J. [Signature]   |  |  |   |  |                                       |

RECEIVED

COMMUNICATIONS

UNITED STATES



OFFICE OF THE SECRETARY OF DEFENSE

ATTENTION: SECRETARY

WASHINGTON, D.C. 20301

DATE: 10/10/64

FROM: [illegible]

SUBJECT: [illegible]

REFERENCE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  | REG. NO.      |  |
|---|--|---|--|---|--|--|--|--|--|---------------|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  |  |  |  |  | 8 1 2 7 9 8 0 |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Wile Ray Terwilliger</b>   |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-19-81</b>   |  | 2b. HOUR<br><b>6:15AM</b>  |  |               |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 16, 1924</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>57</b>   |  | IF UNDER 1 YEAR<br>IF UNDER 24 HRS.  |  |               |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL Co</b> MD.   |  |  |  |               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Annapolis</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ANNE ARUNDEL General Hosp</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Lineman</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Utilities</b>  |  |               |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>A.A.</b>  |  | 13c. CITY OR TOWN<br><b>Annapolis</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>1230 Tyler Avenue</b>  |  |               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Clarence Terwilliger</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Violet Smith</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWI 216-16-4889</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Anna M. Terwilliger Same as #13</b>   |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Distress Syndrome</b><br><b>4100</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Acute Myocardial Infarction</b><br>(c) <b>Coronary Artery Bypass, three weeks PTA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |  |  |  |  |               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |  |   |  |  |  |  |  |               |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |               |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |  |  |               |  |
| 22b. SIGNATURE<br><b>Jack Lichtenstein</b> M.D.   |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |  |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jack Lichtenstein MD</b>  |  |   |  |   |  | 22e. ADDRESS<br><b>Annapolis, Maryland</b>   |  |  |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Nov. 21, 1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Annapolis AA MD</b>   |  |  |  |               |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Taylor Funeral Chapel, Annapolis, MD</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 23 1981</b>  |  |  |  |               |  |
|   |  |   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Nathan</b>   |  |  |  |               |  |

MEDICAL CERTIFICATION



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 9 8 1

FOR  
1. STATE  
REGISTRAR

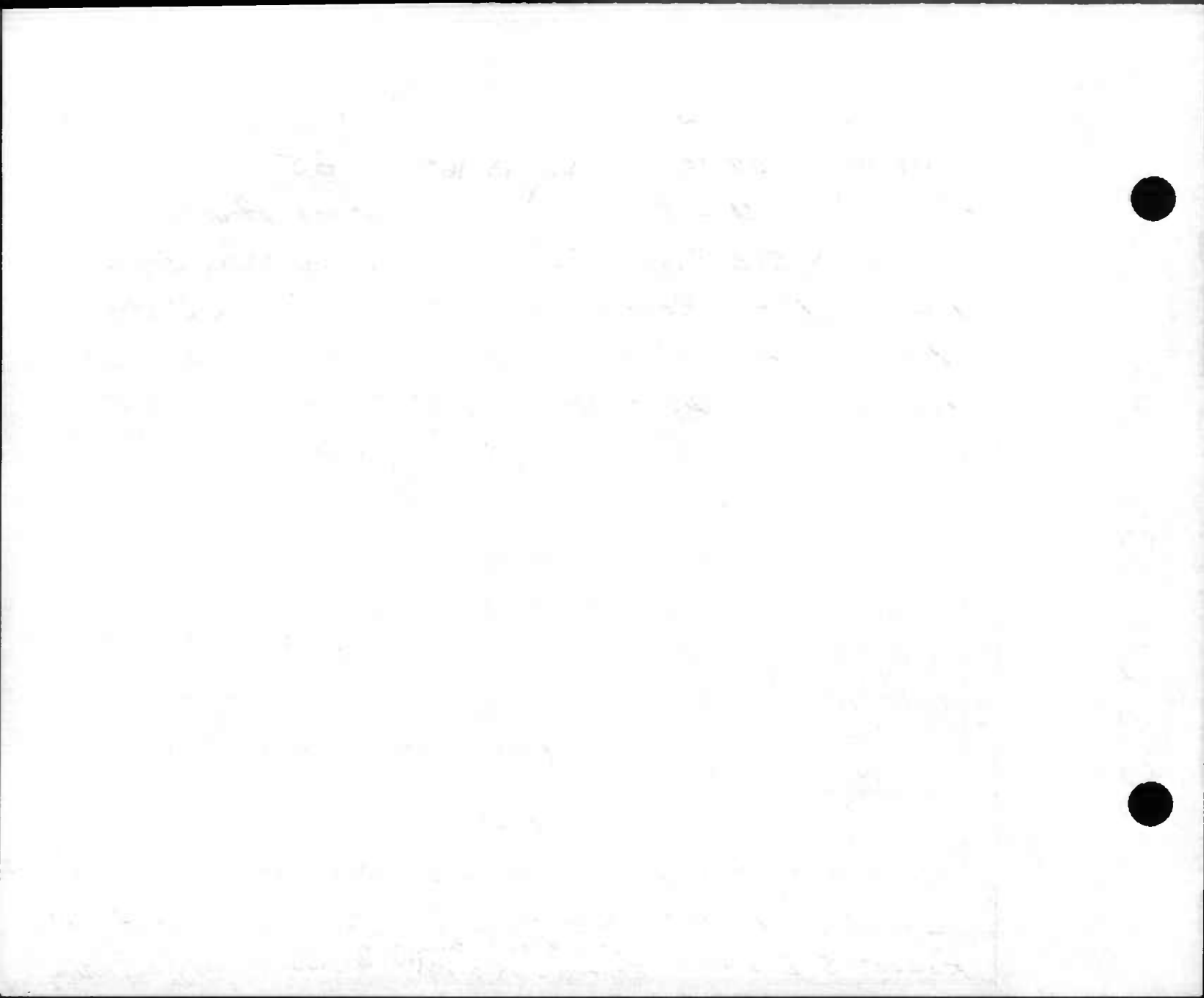
REG. NO.

|   |   |   |   |  |   |
|---|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Martin J. Toskov</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-18-81</b>                                  |  | 2b. HOUR<br><b>6 A.M.</b>   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 13 16</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.                                    |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel</b> MD.                      |   |
| 10. CITY OR TOWN OF DEATH<br><b>Arnold, Md</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>363 Buena Vista</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Snipbuilding</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Drydock</b>   |
| 13a. STATE<br><b>MD.</b>  |   |   | 13b. COUNTY<br><b>A.A.</b>  | 13c. CITY OR TOWN<br><b>Arnold</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Anton F. Toskov</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna M. Doshier</b>                 |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>215-09-7149</b>  |   | 17. INFORMANT<br><b>Margaret M. Toskov</b>   |   |
| ADDRESS<br><b>Sec. 13</b>   |   |   |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4149 Coronary Artery Disease</b><br>IMMEDIATE CAUSE (a) <b>4149</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |   |   |   |  |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____  |   |   |   |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-7-1977</b> to <b>11-18-81</b> , that (I) (we) lost<br>saw the deceased alive on <b>11-12-81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |   |   |   |  |   |
| 22b. SIGNATURE<br><b>Donald H. Hislop</b>   |   | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>11-19-81</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Donald H. Hislop</b>  |   | 22e. ADDRESS<br><b>Robinson &amp; Owens Way. Severna Park Md.</b>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   | 23b. DATE<br><b>11-20-81</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Cem.</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie A.A. MD.</b>            |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert S. Barranco</b>   |   | ADDRESS<br><b>501 R. to Hick Rd. Severna Park Md.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 20 1981</b>                                  |   |
|   |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Frances Jan Warren</b>                              |   |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETURN PAGE 5 TO YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |                       |  |  |
|--|-----------------------|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |                       | 27982  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Stephen Jon VACEK Sr.</b><br><i>Stephen VACEK</i>   |                       | 2a. DATE KNOWN OF<br>DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>11 24 81</b> 2b. HOUR <b>P</b>                            |  |
| 3. SEX <b>M</b>  | 4. RACE <b>W</b>      | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>1 8 56</b>   | 6. AGE (IN YEARS<br>LAST BIRTHDAY) <b>25</b> YRS.  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY) <b>MD</b>   |                       | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |                       | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>A. A. CO.</b>  |  |
| 10. CITY OR TOWN OF DEATH <b>Glen Burnie</b>   |                       | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>North. ARUNDEL Hospital</b>        |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING YEARS) <b>warehouseman</b>  |                       | 12b. KIND OF BUSINESS<br>OR INDUSTRY <b>Castle &amp; Cooke</b>   |  |
| 13a. STATE <b>MD</b>   | 13b. COUNTY <b>AA</b> | 13c. CITY OR TOWN <b>Glen Burnie</b>   | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 14. FATHER'S NAME <b>Jerome J. Vacek</b>   |                       | 15. MOTHER'S MAIDEN NAME <b>Anna May Hanifah</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>NO</b>  |                       | 16b. SOCIAL SECURITY NO. <b>XXXXXXXXXX 215/64/3131</b>   |  |
| 17. INFORMANT <b>Mrs. Debbie Vacek (wife)</b>  |                       | ADDRESS <b>same as 13</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a); (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>gun shot wound chest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                       |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                       |  |  |
| 19a. DATE OF OPERATION   |                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                       |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                       | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 11-24-81</b>  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Self-inflicted gunshot wound</b>   |                       | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK |  |
| 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.) <b>Home</b>   |                       | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>AA CO MD</b>   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                       |  |  |
| ACTUAL SIGNATURE <i>[Signature]</i>  |                       | TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>E. Linhardt</b>   |                       | DATE SIGNED <b>11.24.81</b>  |  |
| ADDRESS <i>[Address]</i>   |                       |  |  |
| 23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>  |                       | 23b. DATE <b>27 Nov 81</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem Pk.</b>   |                       | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Glen Burnie AA MD</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME <i>[Signature]</i> ADDRESS <b>Singleton Funeral Home, Glen Burnie, MD</b>   |                       | 25a. DATE REC'D. BY REGISTRAR <b>NOV 27 1981</b>   |  |
| 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>  |                       |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the filing with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  | 78127983 |
|---|--|--|--|---|--|---|--|--|--|----------|
| 1. FOR STATE REGISTRAR  |  |  |  |   |  |   |  |  |  | REG. NO. |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>JOSE RAMON VEGA Sr.  |  |  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>NOVEMBER 1, 1981  |  | 2b. HOUR<br>7:15 M   |  |          |
| 3. SEX<br>Male  |  | 4. RACE<br>PUERTO RICAN  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>May 13-1931  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>50 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>PUERTO RICO  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ANNE ARUNDEL COUNTY MD.                                 |  |  |  |          |
| 10. CITY OR TOWN OF DEATH<br>GLEN BURNIE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NORTH ARUNDEL HOSPITAL |  |   |  | 12a. USUAL OCCUPATION OF BUSINESS OR INDUSTRY<br>Revermar Corp<br>Rolls Stock Coordinator       |  |  |  |          |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>Md. A.A. Crownsville  |  |  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>Box 1480 Waterbury Road   |  |          |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Unknown VEGA   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>NATILIA GARCIA  |  |   |  |  |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>KOREAN C. L954-57  |  |  |  | 16b. SOCIAL SECURITY NO.<br>582-26-5750   |  | 17. INFORMANT ADDRESS<br>Mary E. Vega Same as 13 E  |  |  |  |          |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u></u><br>4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Days years |  |  |  |   |  |   |  |  |  |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>  |  |  |  |   |  |   |  |  |  |          |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |          |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |          |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-30-81</u> to <u>11-1-81</u> , that (I) (we) last saw the deceased alive on <u>11-1-81</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |          |
| 22b. SIGNATURE <u>J. I. Stern</u> DEGREE  |  |  |  | 22c. DATE SIGNED <u>11-1-81</u>   |  |   |  |  |  |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JACK I. STERN, M.D.  |  |  |  | 22e. ADDRESS<br>300 Hospital Drive #135<br>Glen Burnie, Maryland 21061  |  |   |  |  |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>11-5-81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. Veterans  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Crownsville A.A. Md.                                 |  |  |  |          |
| 24. FUNERAL DIRECTOR<br>G.E. WICKS 111 -1922 Forest Dr. Anna. Md.   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 10 1981  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles J. Nathan</u>   |  |          |

1870-1871

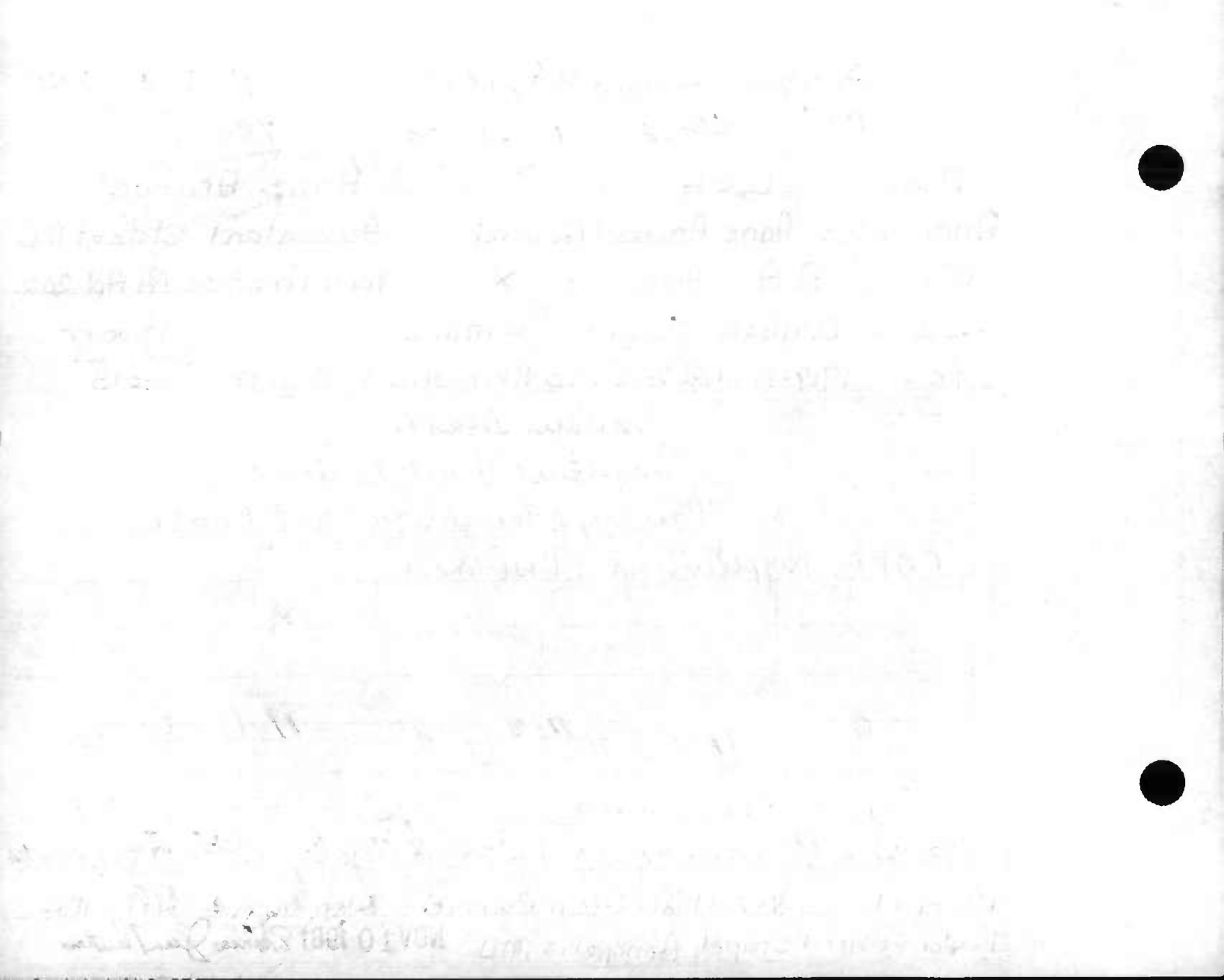
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death, and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of occurrence.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |   |   | REG. NO. 8127984   |  |
|--|--|---|--|---|--|--|--|---|---|--|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>George Edward Wagner</b>   |  |   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11 7 81</b>  |   | 2b. HOUR<br><b>6:10 P.M.</b>   |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>1 29 03</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS<br><b>78</b>                                   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br><b>0 0 0</b>  |   | 8. IF UNDER 24 HRS. HOURS MIN.<br><b>0 0</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel MD.</b>                    |  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Annapolis</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Anne Arundel General</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Accountant</b> |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>State of MD</b> |  |  |
| 13a. STATE<br><b>MD</b>  |  |   |  |   |  | 13b. COUNTY<br><b>A.A.</b>   |  | 13c. CITY OR TOWN<br><b>Annapolis</b>   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Louis William Wagner</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Emma Hoerr</b>   |  |   |  | 16. STREET ADDRESS<br><b>1004 Primrose Rd, Apt. 202</b>                            |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>1919-1921262-05-6113</b>   |  | 17. INFORMANT<br><b>Marjorie H. Wagner</b>  |  |  |  | ADDRESS<br><b>Same as #13</b>   |   |  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sudden Death</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Angestual Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cornary Atherosclerotic Heart Disease</b><br>4140<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |  |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>COPD, Hypertension, Pneumonia</b>   |  |   |  |   |  |  |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |   |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>11/6</b> 19 <b>81</b> , to <b>11/7</b> 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>11/7</b> 19 <b>81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) did not view the body after death.   |  |   |  |   |  |  |  |   |   |  |  |
| 22b. SIGNATURE<br><b>George C. Sammons</b>   |  | DEGREE  |  |   |  | 22c. DATE SIGNED<br><b>11/7/81</b>   |  |   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>George C. Sammons</b>  |  | 22e. ADDRESS<br><b>205 Ridgely Bvd. Annapolis, MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |  |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Nov. 11, 1981</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Burnie</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Glen Burnie A.A. MD</b>              |  |   |   |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Taylor Funeral Chapel, Annapolis, MD</b>   |  | ADDRESS   |  | 25. DATE REC'D. BY REGISTRAR<br><b>NOV 10 1981</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Harkness</b>                             |  |   |   |  |  |

MEDICAL CERTIFICATION



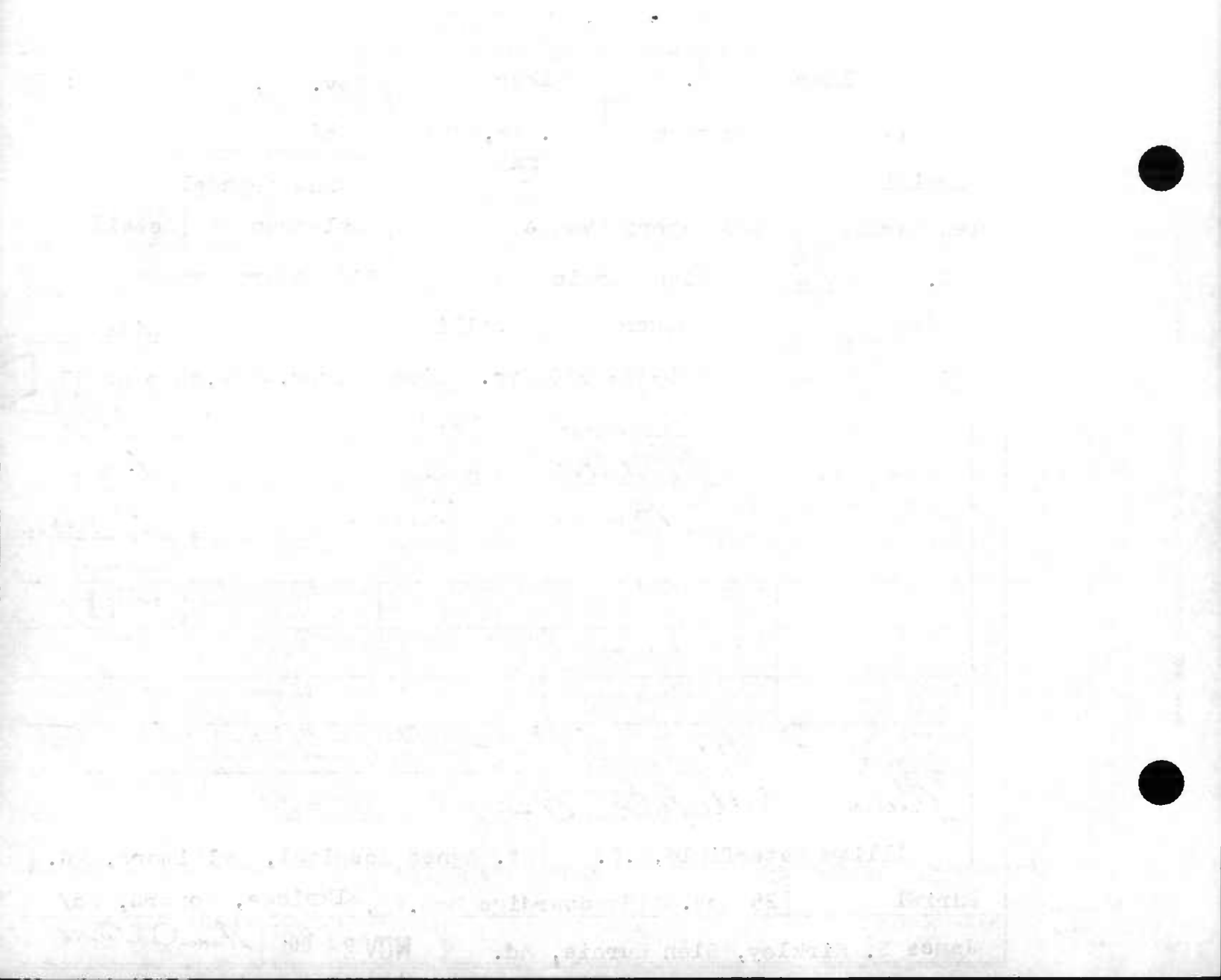
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 1 2 7 9 8 5   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Elmer K. Walker   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>Nov. 22, 1981   |  | 2b. HOUR<br>12:15p  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Mar. 16, 1917  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br>64  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Glen Burnie  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>440 Rogers Avenue |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Salesman   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Retail   |  |
| 13a. STATE<br>Md.   |  |   |  | 13b. COUNTY<br>AA   |  | 13c. CITY OR TOWN<br>Glen Burnie  |  |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  | 13e. STREET ADDRESS<br>440 Rogers Avenue  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Coley Walker   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Hallie White  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes WW 2   |  | 16b. SOCIAL SECURITY NO.<br>216-12-2619   |  | 17. INFORMANT ADDRESS<br>Mrs. Alice Walker, wife, same as 13  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic carcinoma</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Benign Carcinoma</u>   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 mo<br>6 mo<br>2 yrs   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1):  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/30</u> 19 <u>81</u> to <u>11/22</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>11/20</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><u>William C. Waterfield</u> DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |   |  | 22c. DATE SIGNED  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>William Waterfield, M.D.   |  |   |  | 22e. ADDRESS<br>St. Agnes Hospital, Baltimore, Md.  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>25 Nov. 81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Mem. PK.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Elkridge, Howard, Md.  |  |
| 24. FUNERAL DIRECTOR NAME<br>James S. Kirkley, Glen Burnie, Md.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 24 1981  |  | 25b. REGISTRAR'S SIGNATURE<br><u>James S. Kirkley</u>   |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 9 8 6

1. FOR  
STATE  
REGISTRAR

REG. NO.

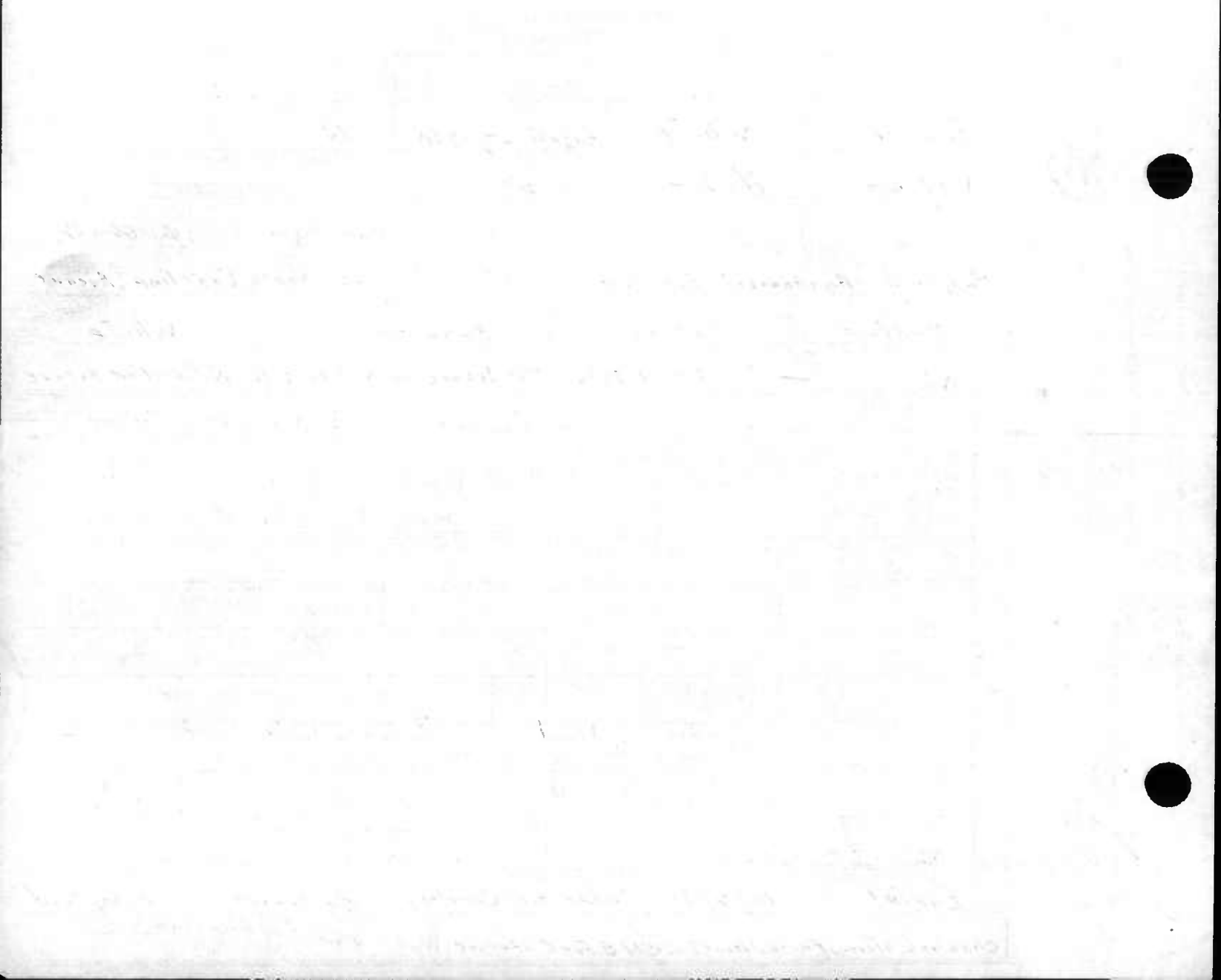
EST

|   |   |   |  |   |   |
|---|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>VIRGINIA M. WALTER</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 2, 1981</b> |   | 2b. HOUR<br>P M<br><b>7:09 P</b>  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>                         | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>August 29, 1908</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>73</b>                                |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD.</b>                          |   |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>   |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b>                  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Class Inspector</b>      |   |
| 13a. STATE<br><b>Maryland</b>   |   | 13b. COUNTY<br><b>AnneArundel</b>   | 13c. CITY OR TOWN<br><b>Pasadena</b>                           | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MURDOCK</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>BARBARA</b>   |  | 16. STREET ADDRESS<br><b>120 North Carolina Avenue</b>  |   |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |   | 17b. SOCIAL SECURITY NO.<br><b>219-18-5653</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>MRS. Jeannette R. MYERS 120 N. Carolina Avenue</b>               |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive heart failure.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Auto myocardial infarct.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>10 chemical heart disease</b> |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Even.</b><br><b>2 days.</b><br><b>2 years.</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:6   |   |   |  |   |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/1/81</b> to <b>11/2/81</b> , that (I) (we) lost saw the deceased alive on <b>11/2/81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |  |   |   |
| 22b. SIGNATURE<br><b>Gerard Church</b>  |   | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>11/4/81</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GERARD CHURCH, M.D.</b>   |   | 22e. ADDRESS<br><b>8 Evergreen Road<br/>Severna Park, Maryland 21146</b>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |   | 23b. DATE<br><b>11/6/81</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>                                |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>   |   | 23e. DATE REC'D. BY REGISTRAR<br><b>NOV 5 1981</b>  |  |   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Charles L. Stevens, Funeral Home, Inc.</b>   |   | ADDRESS<br><b>1501 E. Fort Avenue</b>   |  |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Division of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

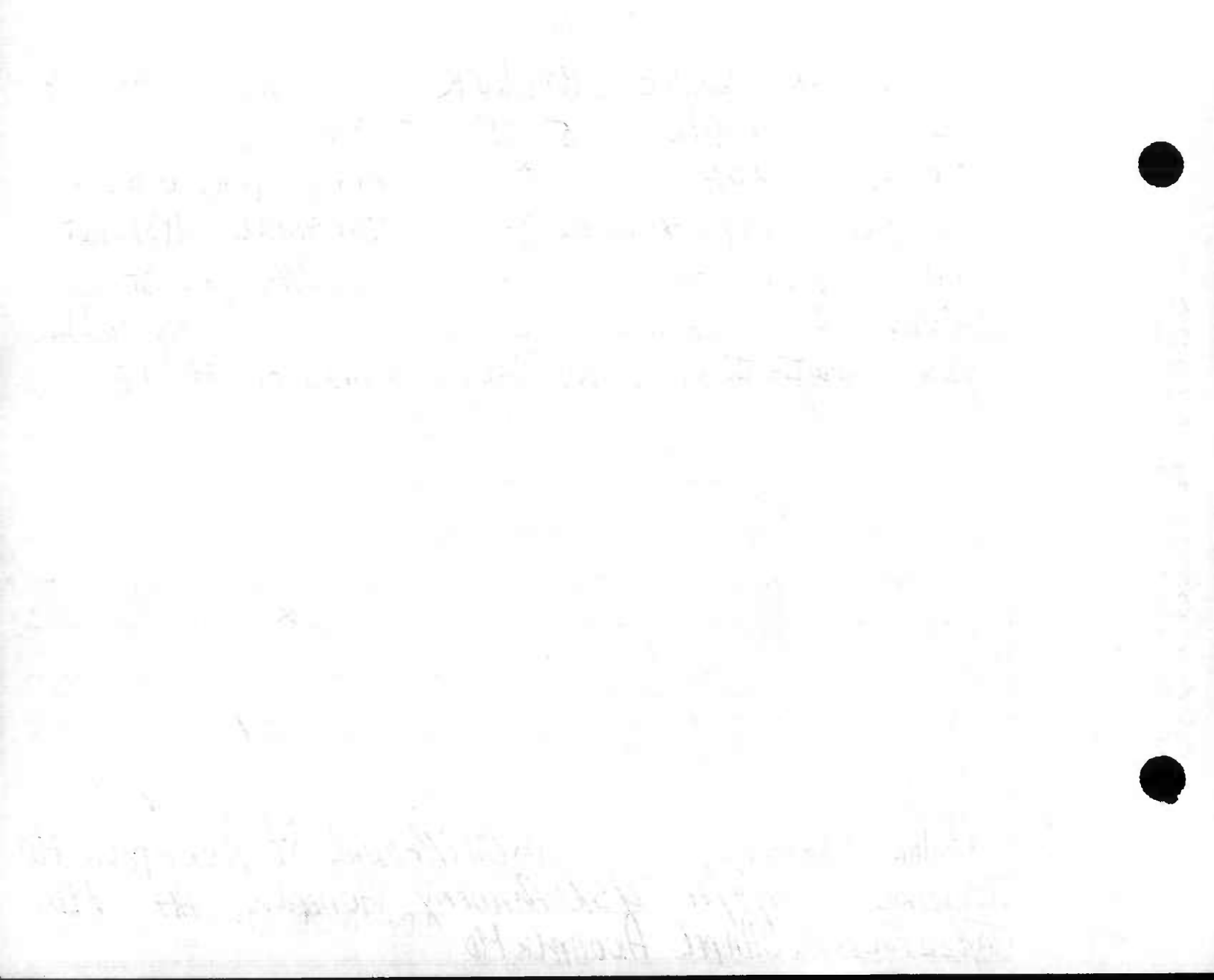
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 9 8 1

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>William Walter Warhick</b>   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov 1 1981</b>  |   | 2b. HOUR<br><b>AM</b>   |   |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 25 1895</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b>  |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>TEXAS</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ADVE ARUNDEL MD.</b>                                 |   |
| 10. CITY OR TOWN OF DEATH<br><b>ANNAPOHIS</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>131 CHARLES ST.</b> |   | 12a. USUAL OCCUPATION<br>(IF DECEASED WAS NOT OF WORKING AGE)<br><b>ADMIRAL USN RET</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY                             |
| 13a. STATE<br><b>MD.</b>  |   | 13b. COUNTY<br><b>HA</b>  | 13c. CITY OR TOWN<br><b>ANNAPOHIS</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>131 CHARLES ST.</b>                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Calvin L. Warhick</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ESSIE CAMPBELL</b>  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>219-40-3454</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>MARY B. Warhick #13</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Vascular accident</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |   |   |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11/30 1981</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>11/30 1981 to 11/7 1981</b>             |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>11/30 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |   |   |   |   |   |
| 23a. SIGNATURE<br><b>Richard Preker</b>   |   | DEGREE  |   | 23b. DATE SIGNED<br><b>10/2/81</b>  |   |
| 24a. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Richard Preker</b>  |   | 24b. ADDRESS<br><b>121 CATHEDRAL ST. ANNAPOLIS MD.</b>  |   |   |   |
| 25a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |   | 25b. DATE<br><b>11/4/81</b>   |   | 25c. NAME OF CEMETERY OR CREMATORY<br><b>USN ACADEMY</b>  |   |
| 25d. LOCATION<br>CITY OR TOWN<br><b>ANNAPOLIS MD.</b>   |   | 25e. LOCATION<br>CITY OR TOWN<br><b>HA MD.</b>  |   |   |   |
| 26. FUNERAL DIRECTOR<br>NAME<br><b>TAYLOR FUNERAL CHAPEL</b>  |   | ADDRESS<br><b>ANNAPOLIS MD.</b>   |   | 27. DATE RECEIVED BY BALTIMORE CITY REGISTRAR'S SIGNATURE<br><b>NOV 3 1981</b>                  |   |



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DHMH-16 30M 2/80  
(VRA 15, 4)

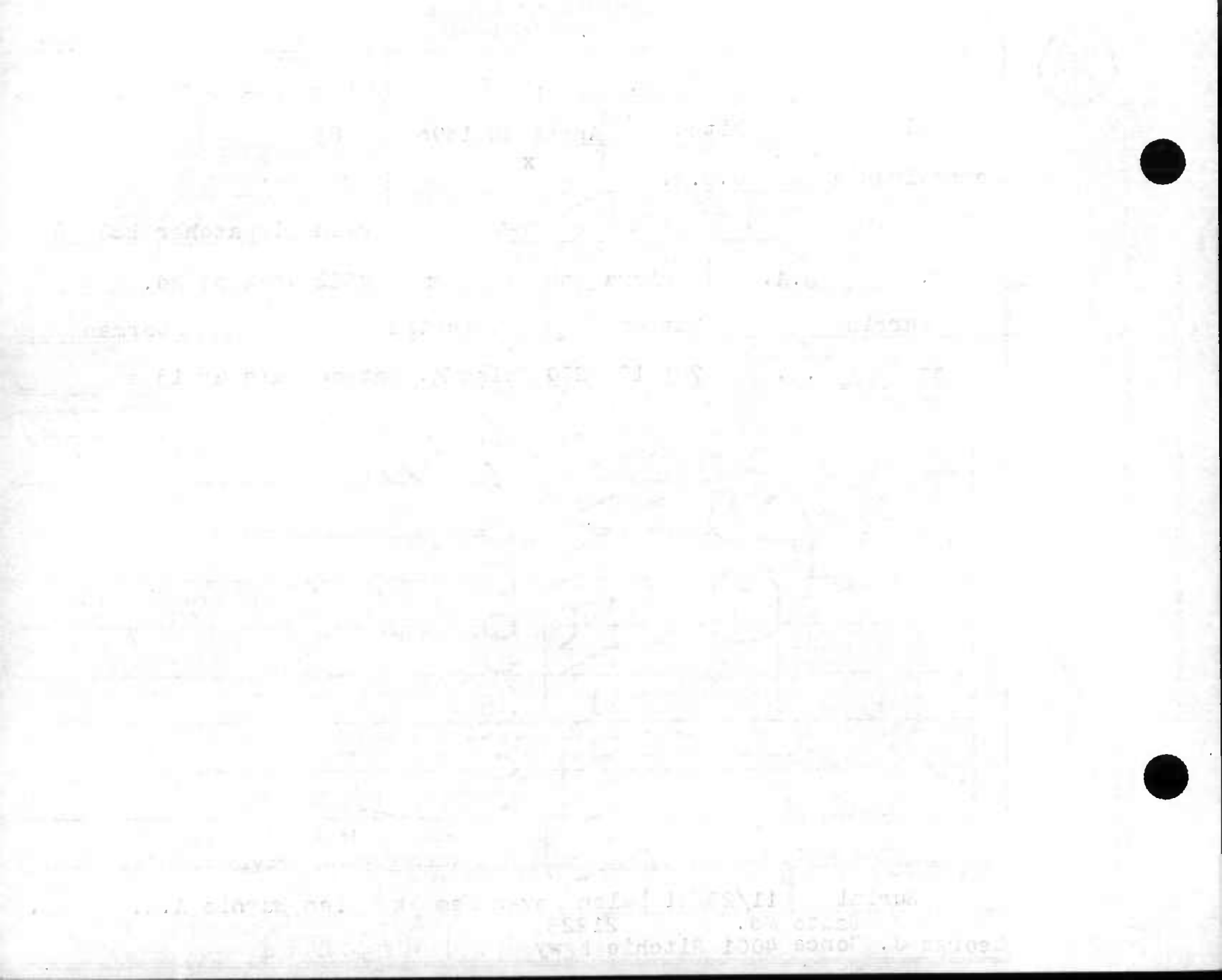
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |   |  |  |  |
|--|--|---|--|---|---|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.  |  | EST   |   | 8 1 2 7 9 8 8   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>CLAUDE MUSSER WATSON  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 20, 1981        |   |  | 2b. HOUR<br>6:25 M.  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 30 1896   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ANNE ARUNDEL COUNTY, MD.                                |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>GLEN BURNIE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NORTH ARUNDEL HOSPITAL |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Train Dispatcher B&O RR     |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY<br>A.A.   |  | 13c. CITY OR TOWN<br>Riviera Bch  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>8522 Jenkins Rd.  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Harris Watson  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Bertha Poorman |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>W.W. I   |  | 17. INFORMANT<br>Helen M. Watson same as 13 e   |   | ADDRESS   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Chronic Lymphocytic Leukemia</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Cancer of the skin</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><i>Recep Erol</i>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   |   |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RECEP EROL, M.D.  |  |   |  | 22e. ADDRESS<br>325 Hospital Drive #104<br>Glen Burnie, Maryland, 21061   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>11/23/81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem Pk   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Glen Burnie A.A. Md.                              |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>George J. Gonce  |  |   |  | ADDRESS<br>4001 Ritchie Hgwy  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 23 1981  |  | 25b. REGISTRAR'S SIGNATURE<br><i>James San Martin</i>  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 9 8 9

1. FOR  
STATE  
REGISTRAR

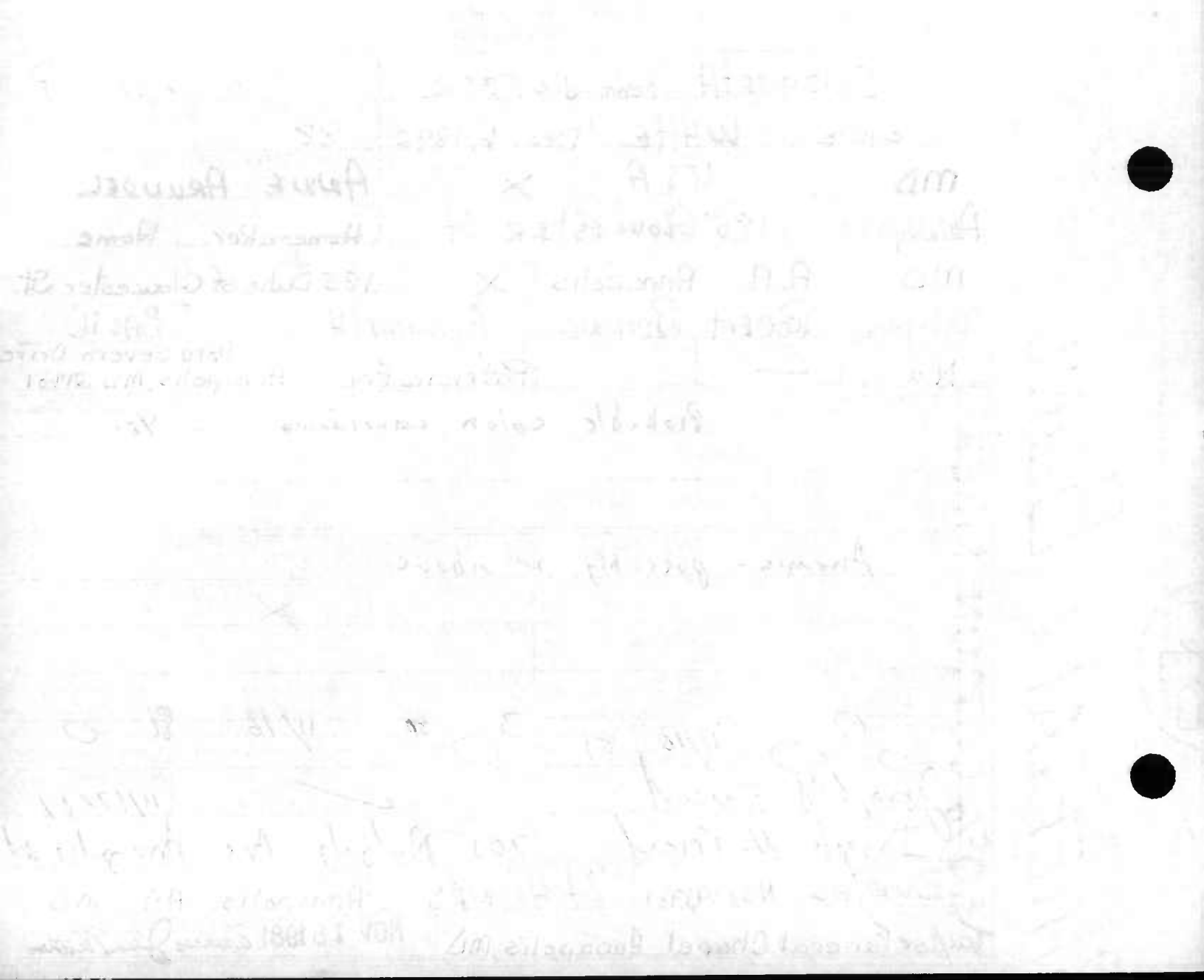
REG. NO.

|  |  |  |  |   |                      |   |  |
|--|--|--|--|---|----------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ELIZABETH Redmond WEBER</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 16 81</b> |   | 2b. HOUR<br><b>P</b> |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 6, 1892</b>   |                      | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel MD</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Annapolis</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT NURSING FACILITY, GIVE STREET ADDRESS)<br><b>185 Gloucester St.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |                      | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>AA</b>   |  | 13c. CITY OR TOWN<br><b>Annapolis</b>   |                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 13e. STREET ADDRESS<br><b>185 Duke of Gloucester St</b>  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Robert Redmond</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Basil</b>   |                      | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |
| 16b. SOCIAL SECURITY NO.<br><b>—</b>   |  | 17. INFORMANT<br><b>Patricia Fry</b>   |  | ADDRESS<br><b>1610 Severn Drive Annapolis, MD 21401</b>   |                      | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Probable colon carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>1539</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>1539</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Anemia - possibly 20 above</b> |  |  |  |   |                      |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)                 |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |                      |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                      | 22a. I certify that (I) (this hospital) attended the deceased from <b>11/10/81</b> to <b>11/16/81</b> , that (I) (we) last saw the deceased alive on <b>11/10/81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                       |  |
| 22b. SIGNATURE<br><b>Joseph N. Friend</b>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |                      | 22c. DATE SIGNED<br><b>11/17/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Joseph N. Friend</b>   |  | 22e. ADDRESS<br><b>205 Ridgely Ave Annapolis, MD</b>   |  |   |                      |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>Nov. 19, 1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. ANNES</b>  |                      | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Annapolis AA MD</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Taylor Funeral Chapel, Annapolis, MD</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 18 1981</b>   |                      |   |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. Nathan</b>  |                      |   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

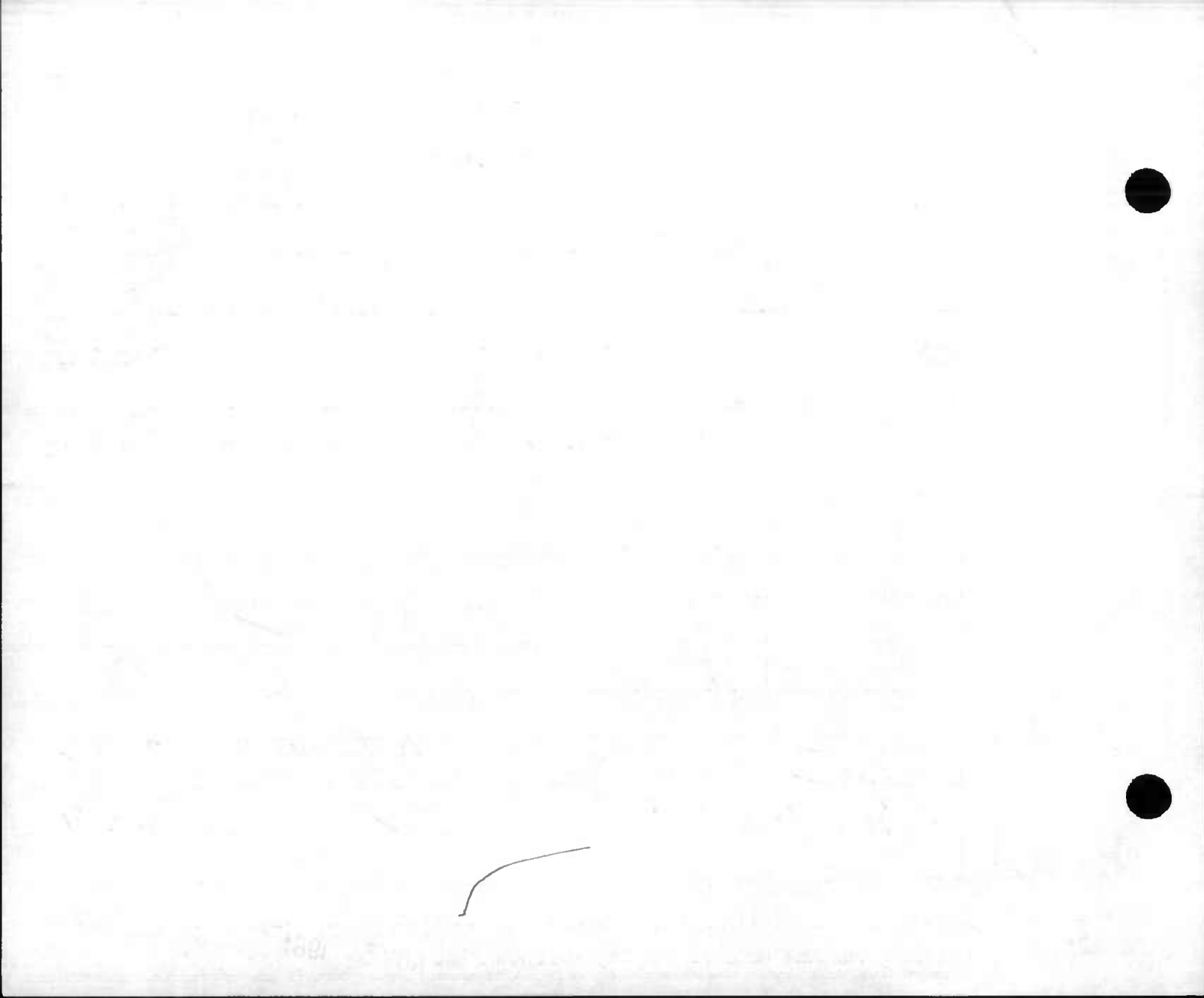
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 9 9 0

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Hattie A. Weber  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Nov. 4 1981 |   |  | 2b. HOUR<br>1:30 PM   |   |
| 3. SEX<br>female  |  | 4. RACE<br>white   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 5, 1901  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.  |   |
| 7a. PLACE OF BIRTH (STATE OR FOREIGN COUNTRY)<br>Wash. D.C.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel Co. MD.                                    |   |
| 10. CITY OR TOWN OF DEATH<br>Edgewater  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1274 Turkey Pt. Rd. |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>housewife   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>household  |   |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>A.A. Co.  |  | 13c. CITY OR TOWN<br>Edgewater  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 13e. STREET ADDRESS<br>1274 Turkey Pt. Rd.  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Harry Hall   |  |   |  |   |   |
| 15. MOTHER'S MAIDEN NAME<br>MIDDLE LAST<br>Lillian Gingell  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  |   |  |   |   |
| 16b. SOCIAL SECURITY NO.<br>577-48-4008   |  | 17. INFORMANT<br>ADDRESS<br>Doris Higham same as 13e.  |  |   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Metastatic Ca. Primary unknown<br>1991<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>6 mos  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |   |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 75 to Nov. 4 19 81, that (I) (we) lost<br>saw the deceased alive on Nov. 1 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death. |  |  |  |   |  |   |   |
| 22b. SIGNATURE<br>R. B. Hall M.D.   |  |  |  | DEGREE  |  | 22c. DATE SIGNED<br>11/5/81   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>11/6/81   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery   |  | 23d. LOCATION<br>CITY OR TOWN<br>Suitland, Md.  |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Hardesty Funeral Home 12 Ridgely Ave. Ann. Md.  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 5 1981   |  |   |   |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |           |  |                                 |  |                     |
|---|-----------|--|---------------------------------|--|---------------------|
| 1. FOR REGISTRAR  |           | 2a. DATE KNOWN OF DEATH  |                                 | 2b. HOUR   |                     |
| 1. DECEASED NAME (TYPE OR PRINT)  |           | 2a. DATE KNOWN OF DEATH  |                                 | 2b. HOUR   |                     |
| FIRST MARRIA  |           | MONTH DAY YEAR 11 1 1981   |                                 | A M  |                     |
| MIDDLE E.   |           | 2c. DATE PRONOUNCED DEAD   |                                 | 2d. HOUR   |                     |
| LAST WENZEL   |           | MONTH DAY YEAR 11-1 1981   |                                 | A M  |                     |
| 3. SEX F  | 4. RACE W | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YR.  | 7. IF UNDER 24 HRS. |
|   |           | MONTH DAY YEAR Jan. 26 1903  | 78 YRS.                         | MONTHS DAYS  | HOURS MIN.          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |           | 7b. CITIZEN OF WHAT COUNTRY?   |                                 | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                     |
| N. Germany  |           | USA  |                                 | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                     |
| 10. CITY OR TOWN OF DEATH   |           | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF OF IN SUCH FACILITY, GIVE STREET ADDRESS) |                                 | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |                     |
| Annapolis   |           | Anne Arundel General   |                                 | Homemaker  |                     |
| 12b. KIND OF BUSINESS OR INDUSTRY   |           | 13a. STREET ADDRESS  |                                 | 13b. CITY OR TOWN  |                     |
| N/A   |           | 6507 Buckingham Palace Court   |                                 | Alexandria   |                     |
| 13a. STATE  |           | 13b. CITY OR TOWN  |                                 | 13c. INSIDE CITY LIMITS?   |                     |
| Virginia  |           | Fairfax  |                                 | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                     |
| 14. FATHER'S NAME   |           | 15. MOTHER'S MAIDEN NAME   |                                 | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |                     |
| FIRST MIDDLE LAST Frederick Landmann  |           | FIRST MIDDLE LAST Matilda Stuebing   |                                 | (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |                     |
| 16b. SOCIAL SECURITY NO.  |           | 17. INFORMANT  |                                 | 17. ADDRESS  |                     |
| None  |           | Son - Same as Item #13   |                                 |  |                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |           |  |                                 |  |                     |
| PART I DEATH WAS CAUSED BY:   |           |  |                                 |  |                     |
| 4149 IMMEDIATE CAUSE (a) Coronary Artery Disease  |           |  |                                 |  |                     |
| DUE TO, OR AS A CONSEQUENCE OF (b)  |           |  |                                 |  |                     |
| Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last.   |           |  |                                 |  |                     |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |           |  |                                 |  |                     |
| 19a. DATE OF OPERATION  |           | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                                 | 20. AUTOPSY?   |                     |
|   |           |  |                                 | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                     |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |           | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                     |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |           | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |                                 | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |                     |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |           |  |                                 |  |                     |
| ACTUAL SIGNATURE  |           | TITLE (SPECIFY)  |                                 | DATE SIGNED  |                     |
| E. Linhardt   |           | M.D. Deputy  |                                 | 11-1-81  |                     |
| EXAMINER'S NAME (TYPE OR PRINT)   |           | ADDRESS  |                                 |  |                     |
| E. Linhardt   |           | Annapolis-MD   |                                 |  |                     |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |           | 23b. DATE  |                                 | 23c. NAME OF CEMETERY OR CREMATORY   |                     |
| Burial  |           | Nov. 4 81  |                                 | Mount Comfort Cemetery   |                     |
| 23d. LOCATION CITY OR TOWN  |           | 23e. COUNTY  |                                 | 23f. STATE   |                     |
| Alexandria  |           |  |                                 | Va.  |                     |
| 24. FUNERAL DIRECTOR NAME   |           | 24b. DATE REC'D. BY REGISTRAR  |                                 | 24c. REGISTRAR'S SIGNATURE   |                     |
| Wayne F. Fildes   |           | NOV 8 1981   |                                 | Francis J. Fildes  |                     |
| Demaine Funeral Homes, Inc. Alex. Va. 22314   |           |  |                                 |  |                     |

W. E. 264

1904

John H. ...

George ...

...

1904

...

...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be notified at once.

BP

DHMH - 16.50M.1/81  
(VRA 15.4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

81 27992

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|   |   |   |   |   |  |  |  |
|---|---|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>William H. Whalen</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 11, 1981</b> |   |  | 2b. HOUR<br><b>7:20 P.M.</b>   |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 25, 1935</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>46</b>  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MD.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Anne Arundel MD.</b>                       |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>ANNAPOILIS</b>  |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>General</b>                                 |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR NA. OF WORKING LIFE)<br><b>Electrician</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Civil Service</b>  |  |
| 13a. STATE<br><b>MD.</b>  |   | 13b. COUNTY<br><b>A.A.</b>  |   | 13c. CITY OR TOWN<br><b>Edgewater</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Laurence Whalen</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Walton</b>  |   | 16. SOCIAL SECURITY NO.<br><b>216-32-5686</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>216-32-5686</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>PATRICIA A. Whalen #13</b>                             |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cervicoma Chung</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>months</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>  |   |   |   |   |  |  |  |
| 9a. DATE OF OPERATION   |   | 19b. CONDICTION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)        |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>NOV 3</b> , 19 <b>80</b> , to <b>NOV 11</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>NOV 11</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>E. Linhart</b>   |   |   |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>11-12-81</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>E. LINHART</b>  |   |   |   | 22e. ADDRESS<br><b>Annapolis - MD</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)<br><b>BURIAL</b>   |   | 23b. DATE<br><b>11/13/81</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Cemetery</b>                       |  | 23d. LOCATION<br>(CITY OR TOWN)<br><b>Annapolis A.A. MD.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>John M. Taylor &amp; Sons Annapolis, MD.</b>   |   |   |   | 25. DATE RECEIVED BY HEALTH DEPT. REGISTRAR'S SIGNATURE<br><b>NOV 16 1981</b>         |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1 - FOR  
STATE  
REGISTRAR

REG. NO.

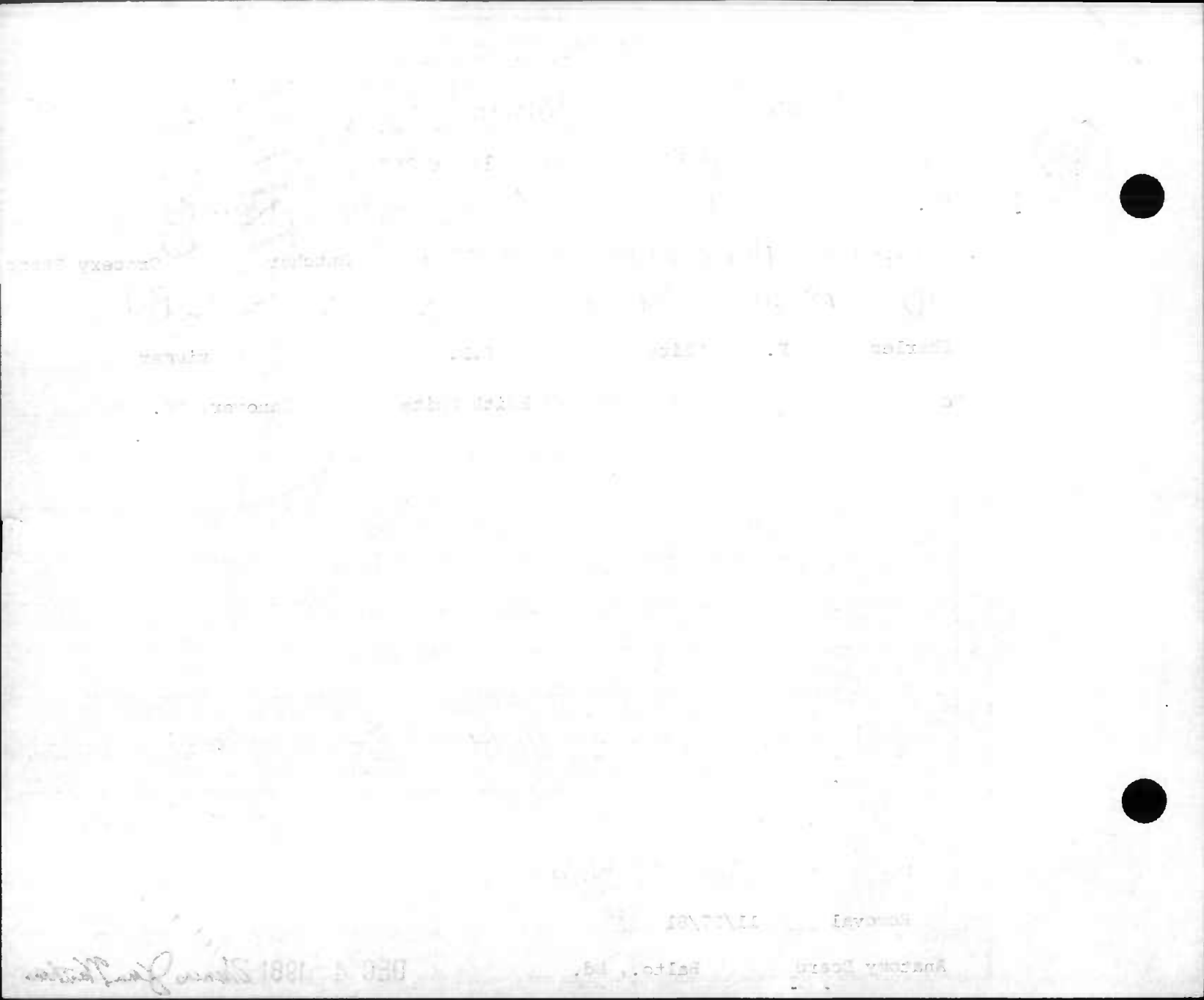
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|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | MILTON<br>MIDDLE<br>LAST<br>White   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 26 81   |  | 2b. HOUR<br>8:43 A.M.  |  |
| 3. SEX<br>male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 21 03  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel Co. MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Annapolis  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Anne Arundel Gen Hosp. |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Butcher   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Grocery Store   |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY<br>ANNE ARUNDEL   |  | 13c. CITY OR TOWN<br>Hanover  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles P. White  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>S.E. Brimmer   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>215-03-9044   |  | 17. INFORMANT<br>Edith White  |  | ADDRESS<br>Hanover, Md.   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Lymphoma</u><br>2028<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 yrs. |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> WHILE AT HOME <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/25</u> , 19 <u>81</u> , to <u>11/26</u> , 19 <u>81</u> , that (I) (we) lost the deceased alive on <u>11/25</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Richard Peeler</u>   |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br>11/26/81   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Richard Peeler, M.D.   |  | 22e. ADDRESS  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Removal  |  | 23b. DATE<br>11/27/81   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Anatomy Board Balto., Md.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 4 1981   |  | 25b. REGISTRAR'S SIGNATURE<br>James J. Nathan  |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

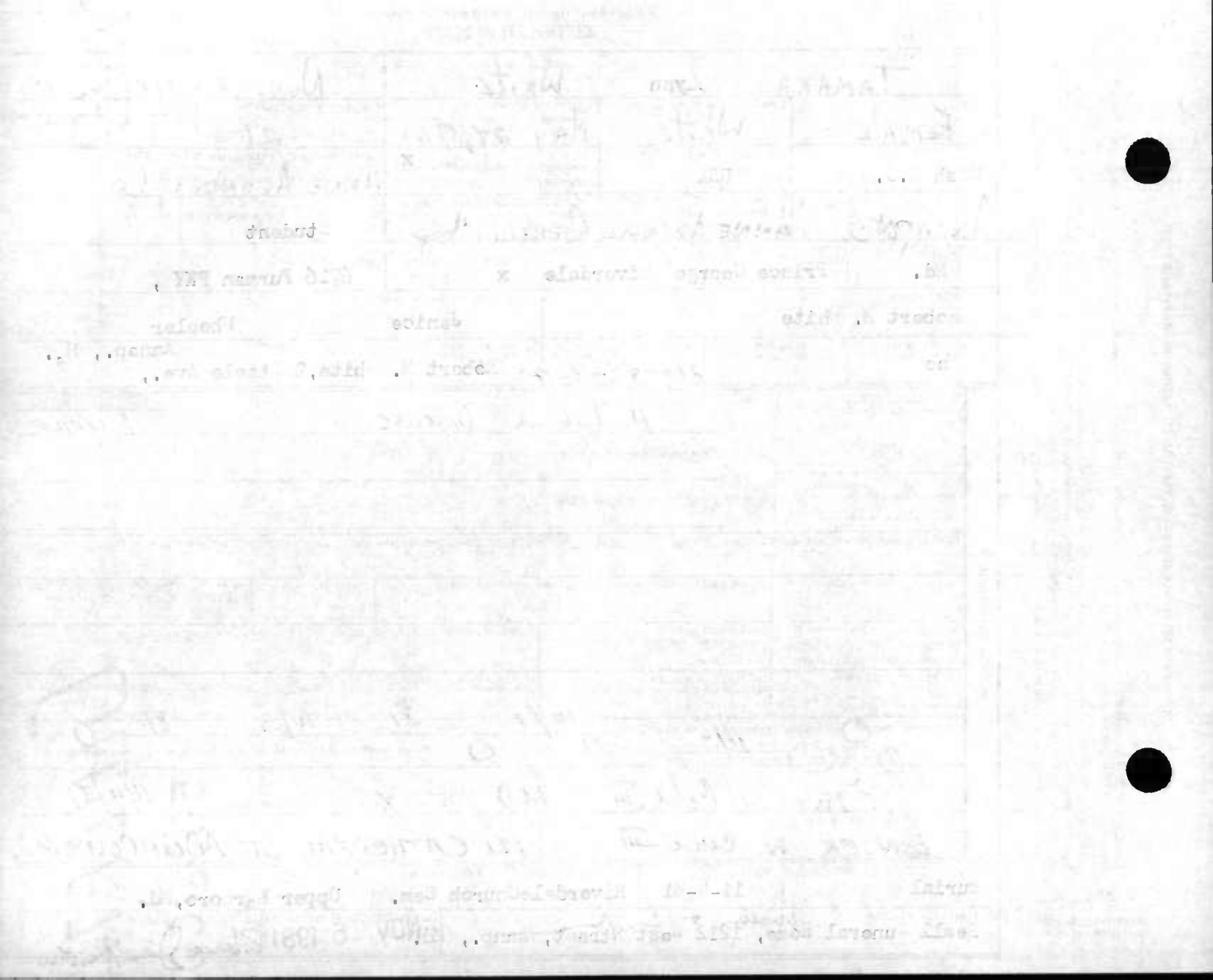
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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STATE  
REGISTRAR

REG. NO.

|   |   |  |  |  |  |
|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>TAMARA Lynn White</b>  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 03, 1981</b>                        |  | 2b. HOUR<br><b>2:53 AM</b>   |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAY 28, 1960</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>21</b> YRS.                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wash D.C.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL Co</b> MD.             |  |
| 10. CITY OR TOWN OF DEATH<br><b>ANNAPOLIS</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ANNE ARUNDEL GENERAL Hosp</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Student</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <b>Prince George</b> 13c. CITY OR TOWN <b>Riverdale</b>   | 13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>6716 Furman PKY,</b>                                     |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert M. White</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Janice Wheeler</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>  | 16b. SOCIAL SECURITY NO.<br><b>215-88-8540</b>  | 17. INFORMANT<br>ADDRESS<br><b>Robert M. White, 2 Steele Ave., Annap., Md.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hodgkins Disease</b><br><b>2019</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 year</b>            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>10/1 81</b><br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>10/1 81 11/3 81</b>    |  |
| 22a. I certify that (I) (his hospital) attended the deceased from <b>10/1 81</b> to <b>11/3 81</b> , that (I) (we) lost saw the deceased alive on <b>11/3 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Enser W. Cole, M.D.</b>  |   | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>11/4/81</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ENSER W. COLE, M.D.</b>   |   | 22e. ADDRESS<br><b>121 CATHEDRAL ST ANNAPOLIS MD.</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |   | 23b. DATE<br><b>11-4-81</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Riverdale Church Cem.</b>                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Upper Marlboro, Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>Beall Funeral Home, 1212 West Street, Annap., Md.</b>  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 5 1981</b>                                 |  |  |
|   |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Nathan</b>                               |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
15M7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|  |                     |  |   |   |                     |   |                      |  |
|--|---------------------|--|---|---|---------------------|---|----------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>John S. Whittington</i>   |                     |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <i>11 28 19 81</i> |   |                     | 2b. HOUR<br><i>2 PM</i>   |                      |  |
| 3. SEX<br><i>M</i>   | 4. RACE<br><i>W</i> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>10 11 24</i>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><i>57</i> YRS.    | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   | 8. IF UNDER 24 HRS. | 9. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><i>11 28 19 81</i>                     | 10. HOUR<br><i>P</i> |  |
| 11. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>   |                     | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |   | 13. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |                     | 14. BALTIMORE CITY OR COUNTY OF DEATH<br><i>A.A. Co.</i>                            |                      |  |
| 15. CITY OR TOWN OF DEATH<br><i>Annapolis</i>  |                     | 16. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Home Health Care - Jagers L</i> |   | 17. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Superintendent</i>   |                     | 18. KIND OF BUSINESS OR INDUSTRY<br><i>Maintenance</i>                              |                      |  |
| 19. USUAL RESIDENCE (NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE COUNTY CITY OR TOWN<br><i>Maryland Anne Arundel County Deal</i>  |                     | 20. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 21. STREET ADDRESS<br><i>Deale Beach Road</i>   |                     |   |                      |  |
| 22. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Thomas E. Whittington</i>   |                     | 23. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Irene E. March</i>   |   | 24. INFORMANT<br>ADDRESS<br><i>Joyce E. Whittington</i>   |                     | 25. APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH<br><i>Scenes 5 H 3</i>             |                      |  |
| 26. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><i>yes</i>   |                     | 27. SOCIAL SECURITY NO.<br><i>WW 2 218163241</i>   |   | 28. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Coronary Artery Disease</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <i>4149</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <i>Heart</i> |                     |   |                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                     |  |   |   |                     |   |                      |  |
| 29. DATE OF OPERATION  |                     | 30. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |                     | 31. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                      |  |
| 32. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                     | 33. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |   | 34. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                     |   |                      |  |
| 35. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                     | 36. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |   | 37. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |                     |   |                      |  |
| 38. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                     |  |   |   |                     |   |                      |  |
| 39. ACTUAL SIGNATURE<br><i>E. Hubbard</i>  |                     | 40. TITLE (SPECIFY)<br><i>Deputy</i>   |   | 41. MEDICAL EXAMINER<br>DATE SIGNED <i>11 28 81</i>   |                     |   |                      |  |
| 42. EXAMINER'S NAME<br>(TYPE OR PRINT)<br><i>E. Hubbard</i>  |                     | 43. ADDRESS<br><i>Annapolis</i>  |   | 44. DATE<br><i>11 28 81</i>   |                     | 45. REGISTERED<br><i>1981</i>   |                      |  |
| 46. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>   |                     | 47. DATE<br><i>Dec 1, 81</i>   |   | 48. NAME OF CEMETERY OR CREMATORY<br><i>Mt Zion Cemetery</i>  |                     | 49. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Yorick AA Md</i>                    |                      |  |
| 50. FUNERAL DIRECTOR<br>NAME<br><i>Rausch Funeral Home</i>   |                     | 51. ADDRESS<br><i>Box 45A Owings</i>   |   | 52. DATE<br><i>DEC 2 1981</i>   |                     | 53. REGISTERED<br><i>1981</i>   |                      |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

#5, 21f, per call w/F.H. 11/30/81 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR  
1- STATE  
REGISTRAR

REG. NO. 27996

|   |                       |   |  |   |   |
|---|-----------------------|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>SUZANNE ELIZABETH WILLIAMS   |                       |   | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> 11-25-81<br>19 |   | 2b. HOUR<br>M   |
| 3. SEX<br>female  | 4. RACE<br>white      | 5. DATE OF BIRTH<br>MONTH 9 DAY 17 YEAR 75                                  | 6. AGE (IN YEARS<br>(LAST BIRTHDAY)<br>6 YRS.  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br>Annapolis, Md.  |                       | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Anne Arundel County MD.   |                       | 10. DATE PRONOUNCED<br>DEAD 11-25-81<br>19                                  |  | 2:00AM M  |   |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Anne Arundel General Hospital   |                       | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br>student |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY<br>-----   |   |
| 13a. STATE<br>Md.   |                       | 13b. COUNTY<br>A.A.Co.  | 13c. CITY OR TOWN<br>Harwood   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 13e. STREET ADDRESS<br>4434 Cobalt Dr.  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Leonard Williams   |                       |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Diane Rushing                               |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>no   |                       | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>no               |  | 17. INFORMANT<br>ADDRESS<br>Diane R. Williams same as 13e.  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Smoke and soot inhalation with thermal burns</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.   |                       |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                     |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.   |                       |   |  |   |   |
| 19a. DATE OF OPERATION  |                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                           |  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                       | 21b. TIME OF INJURY<br>11:25 PM 11-24-81<br>P.M. 19                         |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>caught in housefire  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK   |                       | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)<br>home      |  | 21f. LOCATION<br>4434 Cobalt Drive CITY OR TOWN Harwood, Maryland STATE   |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                       |   |  |   |   |
| ACTUAL<br>SIGNATURE<br>Margaret A. Korell   |                       | TITLE (SPECIFY)<br>M.D. Assistant   |  | DATE<br>1-25-81<br>SIGNED   |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Margarita A. Korell, M.D.   |                       | ADDRESS<br>111 Penn Street  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>11/27/81 | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. V.A. Cemetery                     |  | 23d. LOCATION<br>CITY OR TOWN Crownsville, Md. COUNTY STATE   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hardesty Funeral Home 12 Ridgely Ave. Ann. Md.  |                       | 25a. DATE REC'D. BY REGISTRAR<br>NOV 27 1981                                |  | 25b. REGISTRAR'S SIGNATURE<br>Phonice Jan Nathan  |   |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(V R 15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

|   |                         |   |  |   |   |  |   |  |
|---|-------------------------|---|--|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>RELEASE WILSON</b>  |                         |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <b>11 27 81</b>                     |   |   | 2b. HOUR<br><b>2 P M</b>   |   |  |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>NEGRO</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>7 28 1912</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>69 YRS.</b>                     | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>11 27 1981</b>  | 2d. HOUR<br><b>P M</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>SOUTH CAROLINA</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD.</b>                                       |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>ANNAPOLIS</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>18 Johnson Place</b> |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>MARYLAND</b>   |                         | 13b. COUNTY<br><b>A.A.</b>  |  | 13c. CITY OR TOWN<br><b>ANNAPOLIS</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> <b>18 Johnson Place</b> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>QUANCY MURRITT</b>   |                         |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARGARET MURRITT</b> |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>  |                         |   | 16b. SOCIAL SECURITY NO.<br><b>217-34-8880</b>                           |   | 17. INFORMANT<br>ADDRESS<br><b>THOMAS WILSON, Annapolis, Maryland</b>         |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>arteriosclerotic CVS</b><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>Smother</i>  |                         |   |  |   |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |                         |   |  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                        |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19               |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                         |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)              |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                         |   |  |   |   |  |   |  |
| ACTUAL SIGNATURE<br><i>E. Linhardt</i><br>EXAMINER'S NAME (TYPE OR PRINT)<br><b>E. LINHARDT.</b>  |                         |   | TITLE (SPECIFY)<br>M.D. <b>Depu 19</b><br>MEDICAL EXAMINER               |   |   | DATE SIGNED<br><b>11. 27. 81</b>   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |                         |   | 23b. DATE<br><b>12-3-1981</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PINE LAWN MEM. PARK</b>              |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Annapolis A.A. Maryland</b>        |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>WILLIAM REESE &amp; SONS MORTUARY, P.A. Annapolis, Md.</b>   |                         |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 4 1981</b>                       |   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Thomas Van Natten</i>   |   |  |

MEDICAL CERTIFICATION



DATE RECEIVED

1915

1915

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1915

1915

1915

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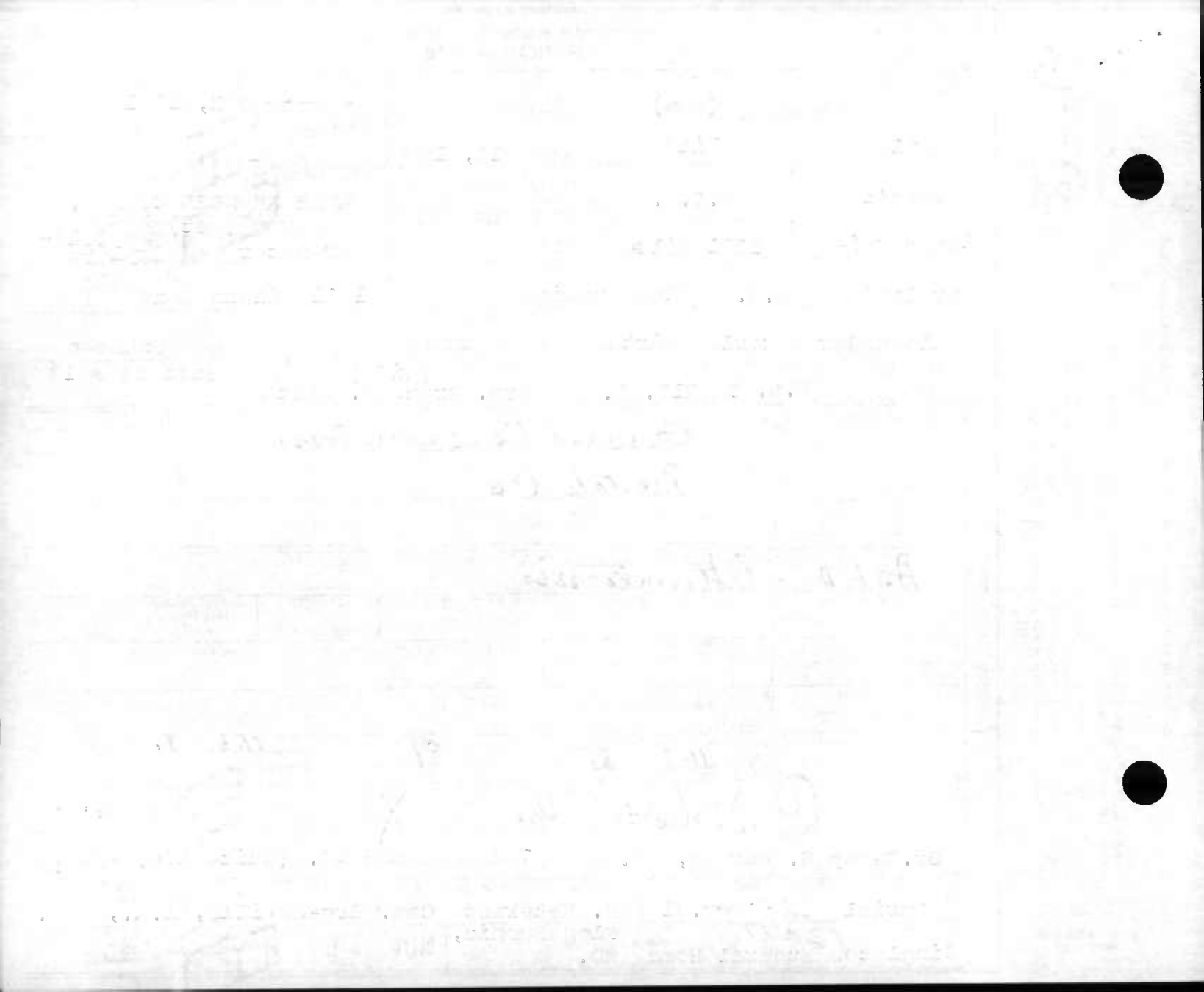
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death—Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed at least 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to the scene.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 2 7 9 9 8

|   |  |   |   |                                   |  |
|---|--|---|---|-----------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 20. DATE OF DEATH   |   | 2b. HOUR                          |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | 20. DATE OF DEATH   |   | 2b. HOUR                          |  |
| HENRY (nmn) WIRTH   |  | November 3, 1981  |   | p <sub>m</sub>                    |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | 7. IF UNDER 1 YEAR                |  |
| Male  | White  | May 12, 1900  | 81 YRS  | MONTHS DAYS HOURS MIN.            |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 9b. CITIZEN OF WHAT COUNTRY?   | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                                   |  |
| Russia  | U.S.A.   |   | ANNE ARUNDEL COUNTY, MD.  |                                   |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (Retiree) (TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| Glen Burnie   | 1221 Wilson Road   | Carpenter   |   | Self-Employed                     |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  | 13b. STATE   | 13c. COUNTY   | 13d. CITY OR TOWN   | 13e. INSIDE CITY LIMITS?          | 13f. STREET ADDRESS                          |
| Maryland  | A.A.   | Glen Burnie   | Yes <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 1221 Wilson Road                  |  |
| 14. FATHER'S NAME   | 15. MOTHER'S MAIDEN NAME   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |   |                                   |  |
| Alexander Carl Wirth  | Anna Unknown   | Yes W.W. I  |   |                                   |  |
| 17. INFORMANT (Wife)  | ADDRESS Same as # 13   |   |   |                                   |  |
| Mrs. Grace E. Wirth   |  |   |   |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |   |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) General Carcinomatosis  |  |   |   |                                   |  |
| 1850 DUE TO, OR AS A CONSEQUENCE OF (b) Prostate Ca   |  |   |   |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |   |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |                                   |  |
| As Hb - Atherosclerosis   |  |   |   |                                   |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                                   |  |
|   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |                                   |  |
|   | HOUR A.M. MONTH DAY YEAR   |   |   |                                   |  |
|   | P.M. 19  |   |   |                                   |  |
| 21d. INJURY OCCURRED  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION   |   |                                   |  |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | STREET CITY OR TOWN COUNTY STATE  |   |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-3-81 to 11-3-81, that (I) (we) last saw the deceased alive on 11-3-81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |                                   |  |
| 22b. SIGNATURE  | 22c. DATE SIGNED   |   |   |                                   |  |
| Dr. Cenap S. Dorkan, MD.  | 4 NOV '81  |   |   |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   | 22e. ADDRESS   | 22f. DATE RECD. BY REGISTRAR  |   |                                   |  |
| Dr. Cenap S. Dorkan, MD.  | 7845 Oakwood Rd. (Suite 204) Glen Burnie   | NOV 5 1981  |   |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION   |                                   |  |
| Burial  | 6 Nov. 81  | MD. Veterans Cem.   | Crownsville, A.A., MD.  |                                   |  |
| 24. FUNERAL DIRECTOR  | 24b. ADDRESS   | 24c. DATE RECD. BY REGISTRAR  |   |                                   |  |
| Singleton Funeral Home  | Glen Burnie, MD.   | NOV 5 1981  |   |                                   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 1 2 7 9 9 9  
E.S.T.

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ANIELA C. WUJCIC</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 19, 1981</b>                      |   | 2b. HOUR<br><b>1:17A</b>   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 20, 1895</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b>   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Poland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Poland</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>ANNE ARUNDEL COUNTY MD.</b>               |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>GLEN BURNIE</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NORTH ARUNDEL HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Anne Arundel</b>  | 13c. CITY OR TOWN<br><b>Pasadena</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>1541 Colony Rd. 21122</b>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jan Malec</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-74-2849</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Frances Hasse Same as #13</b>                               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Embolic CVA</b><br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>Arrival F.b</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>A.S.H.D</b>         |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hours</b><br><b>2 years</b><br><b>years</b>                          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>CHDx ; Systemic Emboli</b>   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>11/18/81</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Emboli both femoral arteries</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/17</b> 19 <b>81</b> , to <b>11/19</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>11/19</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Daljit Sawhney M.D.</b>  |  | 22c. DATE SIGNED<br><b>11/19/81</b>   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Daljit Sawhney M.D.</b>                             |  |
| 22e. ADDRESS<br><b>7845 OAKWOOD ROAD SUITE 200 GLEN BURNIE, MARYLAND 21061</b>  |  | 22f. DATE RECEIVED BY REGISTRAR<br><b>NOV 24 1981</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/21/1981</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Rosary Cemetery</b>                               |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Dundalk Balto. Md.</b>   |  | 23e. DATE RECEIVED BY REGISTRAR<br><b>NOV 24 1981</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Mc Cully F.H. Mtn. &amp; Tick Neck Rds., Pasadena Md. 21122</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>James J. Smith</b>   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Signed may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |                     |  | 8 1 2 8 0 0 0   |     |   |          |
|---|--|---|--|---|--|---|--|---------------------|--|-----------------|-----|---|----------|
| FOR<br>1. STATE<br>REGISTRAR  |  | REG. NO.  |  |   |  |   |  |                     |  |                 |     |   |          |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH   |  | MONTH           | DAY | YEAR  | 2b. HOUR |
| CHARLIE E. WYRICK   |  |   |  |   |  |   |  | 11-6-81             |  |                 |     |   | 323A M   |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR     |  | IF UNDER 24 HRS |     |   |          |
| M   |  | Caucasian   |  | 7 16 10   |  | 71  |  | MONTHS              |  | DAYS            |     | HOURS MIN.  |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                     |  |                 |     | MD.   |          |
| Virginia  |  | USA   |  |   |  | Anne Arundel.   |  |                     |  |                 |     |   |          |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                     |  |                 |     |   |          |
| Baltimore   |  | Anne Arundel Hosp.  |  | Retired   |  | Carpenter   |  |                     |  |                 |     |   |          |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS |  |                 |     |   |          |
| MD.   |  | A.A.  |  | Deale   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 626 E Marshall Ave  |  |                 |     |   |          |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |   |  |                     |  |                 |     |   |          |
| Charlie Wyrick  |  | Martha Southernland   |  |   |  |   |  |                     |  |                 |     |   |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | ADDRESS   |  |                     |  |                 |     |   |          |
| NO  |  | 226-09-2711   |  | Ely C. Wyrick   |  | Samson #13  |  |                     |  |                 |     |   |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of lung</u><br><u>1629</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |   |  |                     |  |                 |     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>6 months</u> |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |   |  |   |  |   |  |                     |  |                 |     |   |          |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                     |  |                 |     |   |          |
|   |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                     |  |                 |     |   |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |                     |  |                 |     |   |          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |                     |  |                 |     |   |          |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.                                       |  |   |  |   |  |   |  |                     |  |                 |     |   |          |
| 22b. SIGNATURE  |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED  |  |                     |  |                 |     |   |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | MD  |  | 22e. ADDRESS  |  | 11/6/81   |  |                     |  |                 |     |   |          |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |                     |  |                 |     |   |          |
| Burial  |  | 11/9/81   |  | Highland Burial Park, Denville  |  | Denville - Virginia   |  |                     |  |                 |     |   |          |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REG'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |                     |  |                 |     |   |          |
| John Rausch Owens, Md.  |  | NOV 12 1981   |  | Charles Santhorne   |  |   |  |                     |  |                 |     |   |          |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8128001

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |   |  |   |   |   |  |
|---|--|--|--|---|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Flora Estelle Yockel   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 17, 1981               |   |   | 2b. HOUR<br>12:30 A.M.   |   |   |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 28, 1909   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>ANNE ARUNDEL COUNTY, MD.   |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>ANNAPOLIS  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ANNE ARUNDEL CO. GEN'L. HOSP. |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Postal Clerk   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Civil Service  |   |  |
| 13a. STATE<br>Maryland  |  |  | 13b. COUNTY<br>A.A.  |   | 13c. CITY OR TOWN<br>Pasadena   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br>200 Pleasant View Ave.   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Clarence Johnson  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lena Otterbein        |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No N/A   |   |   |   |  |
| 16b. SOCIAL SECURITY NO.<br>218.42.0930   |  |  | 17. INFORMANT (Son)<br>Mr. Alton J. Yockel, Jr., Pasadena              |   |   | ADDRESS 105 Altona Ave.  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Brain stem stroke with</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Quadriplegia + coma</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive Cardiovascular Disease</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d) |  |  |  |   |   |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |  |   |   |   |  |
| 22b. SIGNATURE<br>Donald Hislop   |  |  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>11/17/81  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Dr. Donald Hislop  |  |  |  |   |   | 22e. ADDRESS<br>Robinson Rd. & Owens Way, Severna Pk.  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  | 23b. DATE<br>20 Nov. 81  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Mem. Pk                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Glen Burnie, A.A., MD.                            |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Singleton Funeral Home  |  |  | ADDRESS<br>MD.   |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 19 1981                                  |  | 25b. REGISTRAR'S SIGNATURE<br>James J. Wether   |   |   |  |

